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*Canada Social Security Special
Committee on, 1943*

SESSION 1943
HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 1

[and reports]

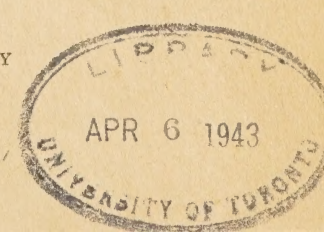
TUESDAY, MARCH 16, 1943

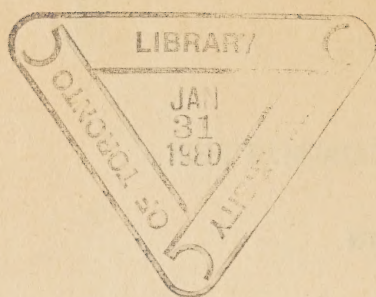
[and 1st Report]

WITNESS:

Hon. I. A. Mackenzie, Minister of Pensions and National Health, and
Chairman of the Cabinet Committee on Reconstruction.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943





ORDER OF REFERENCE

FRIDAY, 8th March, 1943.

Resolved—That a select committee of this House be appointed to examine and report on a national plan of social insurance which will constitute a charter of Social Security for the whole of Canada, and, to that end,

To examine and study the existing social insurance legislation of the Parliament of Canada and of the several provincial legislatures; social insurance policies of other countries; the most practicable measures of social insurance for Canada, including health insurance, and the steps which will be required to effect their inclusion in a national plan; the constitutional and financial adjustments which will be required for the achievement of a nation-wide plan for social security; and other related matters.

That the said committee have power to appoint, from among its members, such subcommittees as may be deemed advisable or necessary to deal with specific phases of the problems aforesaid and call for persons, papers, and records, to print such papers and evidence from day to day as may be ordered by the committee for the use of the committee and members of the House; that the said committee report to the House from time to time; and that the said committee shall consist of the following members: Messrs. Adamson, Blanchette, Bourget, Breithaupt, Bruce, Casselman (Mrs.) (Edmonton East), Claxton, Cleaver, Cote, Diefenbaker, Donnelly, Fauteux, Gershaw, Gregory, Hatfield, Howden, Hurtubise, Johnston (Bow River), Kinley, Lalonde, Leclerc, Lockhart, MacInnis, MacKenzie (Neepawa), Mackenzie (Vancouver Centre), MacKinnon (Kootenay East), Macmillan, McCann, McGarry, McGregor, McIlraith, Mayhew, Mitchell, Picard, Shaw, Slaght, Telford, Veniot, Warren, Wood, Wright, and that the provisions of Standing Order 65, limiting the number of members on special committees, be suspended in relation thereto.

Attest.

ARTHUR BEAUCHESNE,
Clerk of the House.

REPORT TO THE HOUSE

OTTAWA, March 16, 1943.

The Special Committee on Social Security begs leave to present the following
as a

FIRST REPORT

Your Committee recommends that twelve members shall constitute a quorum.
All of which is respectfully submitted.

CYRUS MACMILLAN,
Chairman.

MINUTES OF PROCEEDINGS

TUESDAY, March 16, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock a.m.

The following members were present: Messrs. Blanchette, Bourget, Bruce, Casselman, Mrs. (Edmonton East), Cleaver, Cote, Diefenbaker, Fauteux, Gershaw, Gregory, Hatfield, Hurtubise, Kinley, Leclerc, Lockhart, MacInnis, MacKenzie (Neepawa), Mackenzie (Vancouver Centre), MacKinnon (Kootenay East), Macmillan, McCann, McGregor, McIlraith, Mayhew, Mitchell, Picard, Shaw, Slaght, Telford, Veniot, Warren, Wood, Wright.—33.

On motion of Mr. Gershaw, Hon. Cyrus Macmillan was elected Chairman.

On motion of Mr. Fauteux, Mr. Blanchette was elected Vice-Chairman.

On motion of Mr. Cleaver,

Resolved: That 1,500 copies in English and 700 copies in French of the minutes of proceedings and evidence, and such other papers as are ordered by the Committee, be printed.

Mr. Cleaver moved that the Committee request that its quorum be fixed at 12 members.

Mr. Lockhart moved in amendment thereto that the quorum be fixed at 15 members.

On division the amendment was negatived, and the motion of Mr. Cleaver was adopted.

Hon. Mr. Mackenzie tabled the report of the Advisory Committee on Reconstruction (Dr. L. C. Marsh's Report).

Also, a draft copy of a Bill entitled An Act Respecting Health Insurance, Public Health, the Conservation of Health, the Prevention of Disease and other matters related thereto.

Also, a synopsis or digest on "Social Security for Canada" (*This latter to be printed following the Minister's statement.*)

The decision respecting the printing of the report of the Advisory Committee on "Social Security for Canada", in excess of the number ordered for use of the committee, was left to the Chairman and the Minister of Pensions and National Health.

The printing of the Heagerty Report on National Fitness in excess of number ordered for use of the Committee will be decided upon at the next meeting.

At the suggestion of Mr. McCann, it was agreed that the Chairman appoint a subcommittee on Agenda.

It was agreed that Dr. Heagerty and Dr. Watson would be the witnesses at the next meeting.

The Committee adjourned at 1.00 o'clock p.m., to meet again on Friday, March 19th, at 11 o'clock a.m.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

MARCH 16, 1943.

The Special Select Committee on Social Security met at 11 o'clock a.m. this day. The Chairman, the Hon. Cyrus Macmillan, presiding.

THE CHAIRMAN: Mr. Minister, Mrs. Casselman and gentlemen: I deeply appreciate the honour you have done me in choosing me as your Chairman, and I am sincerely grateful to you also, Dr. Gershaw, for your very kind but quite unmerited remarks with reference to myself. I am sure that we all realize the importance of this committee, the difficulties, the problems and the tasks involved. Whatever the diversity of opinion may be as we proceed I am sure that there will be unanimity of spirit and intention on the part of all of us to do the best we can for the good of this country. Thank you very much.

Mr. BLANCHETTE: I wish to thank the members of the committee for the honour conferred upon me in appointing me its vice-chairman.

The CHAIRMAN: We have the privilege this morning of having the Hon. Ian Mackenzie, Minister of Pensions and National Health, with us. He will present a statement to the committee.

Hon. Mr. MACKENZIE: Mr. Chairman, Mrs. Casselman and gentlemen: I had intended at the conclusion of my remarks to table certain documents but, with your consent, I shall table them at the outset instead. I now place on the table the following reports:

- (1) Report of the Advisory Committee on Health Insurance; appointed by order in council 836, dated February 5, 1942.
- (2) A report on social security for Canada prepared at my request by the Committee on Reconstruction.
- (3) Proposed draft bill for the promotion of physical fitness of the people of Canada; prepared in the Department of Pensions and National Health; together with explanatory memorandum.

I have also here a very brief summary of the report on social security for Canada; and, with the consent of the committee, would like to file this as an addendum to my remarks this morning. This I do for the convenience of members of the committee.

The report of the Advisory Committee on Health Insurance is in seven parts, as follows:

Part 1, the draft bill and a summary of its contents.

Part 2, historical survey of health insurance throughout the world.

Part 3, a summary of the provisions of health insurance in operation in the various countries throughout the world at the present time.

Part 4, a report on existing public health agencies in Canada.

Part 5, a statistical survey of public health in Canada.

Part 6, estimates of the cost of health insurance for Canada.

Part 7, submissions by various organizations to the Advisory Committee on Health Insurance.

And an appendix containing miscellaneous useful information.

I might say that the charts and maps which accompany Part 5 are not contained with the two volumes of the report because they will be handed to you separately.

In passing I may say that this is undoubtedly, in my judgment, the most comprehensive report on health insurance ever compiled in this or any other country and I wish to pay my special tribute to Dr. Heagerty, and the members of his committee, whose unflagging labour of a period of two years in all, and their obvious grasp of the problem is responsible for this achievement.

Then, coming to the report of the advisory committee with respect to social security we have in Part I of that report the basis of the task—that includes, (1) Canadian Perspective; (2) Categories of Social Need; (3) Minimum Standards and Existing Provisions; (4) Securance of the Social Minimum. Part II of that report relates to employment and it comprises four sections and continuing in chronological sequence they are: (5) A National Employment Program; (6) Occupational Readjustment; (7) Unemployment Insurance and (8) Unemployment Assistance. Then in Part III we have reference to the universal risks—sickness, invalidity and old age; in Part IV we have family needs including children's allowances; women's needs in the social security system; widowhood; Mothers' allowances; survivors' insurance, and funeral and other expenses. Then we have Part V, Conclusion—Outlines of a Comprehensive System; Constitutional and Administrative Decisions and Financial Considerations and their relationship. Then, the appendix to the report contains a series of short surveys of existing legislation in the field of workmen's compensation, mothers' allowances, training and placement, industrial retirement plans in Canada and rental variations and the minimum standard.

That concludes a brief summary of the report which I have tabled. Now we pick up, Mr. Chairman, with the Atlantic Charter and so forth.

The Atlantic Charter and the Beveridge Report have given a stimulus to public thinking on the subject of social security, not only in Canada but throughout the world.

The Atlantic Charter issued by President Roosevelt and the Prime Minister of the United Kingdom, on August 14, 1941, places the objective of social security before the United Nations as one of the purposes for which we are fighting the war.

The Charter says in Paragraph 5:—

They (meaning the two nations—Great Britain and the United States) desire to bring about the fullest collaboration between all nations in the economic field with the object of securing for all improved labour standards, economic advancement and social security.

This objective has been subscribed to by the Dominion of Canada on more than one occasion, but it will be sufficient to refer to the Declaration by the United Nations at Washington, on January 1, 1942, in which the Representative of the Canadian government formally subscribed on behalf of Canada to the "common program of purposes and principles embodied in the joint declaration of the President of the United States of America and the Prime Minister of Great Britain and Northern Ireland, dated August 14, 1941, known as the Atlantic Charter."

If there be any suggestion that Canada was not united in subscribing to this Declaration, the platform adopted at Winnipeg by the National Convention of the Progressive Conservative Party may be recited as evidence that as between the two major parties in Canada there is no division of opinion. And I feel sure that is true of the other groups as well.

The Winnipeg Convention adopted as Resolution No. 6, under the heading of "Reconstruction", the following language:—

We believe that the reconstruction of post-war Canadian economy must be based upon the following principle set forth in section 5 of the Atlantic Charter.

That is the section which refers to social security.

The Beveridge Report, which has had such a profound effect upon the world's thinking, contains:—

1. An analysis of the various systems of social insurance, and benefit or pension schemes in effect in the United Kingdom;
2. A recommendation that they be consolidated in a single unified plan of social insurance for all;
3. A recommendation that the existing schemes of social insurance be augmented by benefits for certain additional social hazards not now covered;
4. A recommendation that the scale of benefits (at present very uneven and often below the subsistence level) be based upon an established minimum subsistence standard.

The Beveridge Report is a magnificent and admirable document. It is the work of a most enlightened and progressive authority on social science. Its motives and its reasoning are applicable to humanity everywhere, but its practical recommendations have reference only to the United Kingdom.

The report has been received with wide acclaim by the British people, and it has been read by many Canadians—including myself—with profit and inspiration, but it is not yet a statute, and we cannot say yet that it is entirely practicable even in Great Britain until it has been submitted to the acid test which will come when legal draftsmen and members of parliament seek to translate its far-reaching recommendations into the form of law.

When these very definite and specific recommendations are considered in relation to Canada, it becomes immediately apparent that they are not in all respects applicable.

When Sir William Beveridge recommends unification of existing social services under one ministry and supported by a single contribution, he is dealing with a series of statutes and services enacted by one parliament and administered by one government.

When Sir William Beveridge recommends that the existing benefits be augmented by provision for certain additional hazards that menace the economic security of the working man and his family, the proposed additions are small and incidental as compared with the far-reaching measures already in effect.

If the program advocated by Sir William Beveridge is found to be practical in Great Britain, only one government will have to initiate legislation and one parliament has complete jurisdiction to enact it.

None of these facts is true in Canada.

We have six major social security measures in operation in Canada, and there are three distinct types of legislative authority for them.

Workmen's Compensation and Mothers' Allowances are entirely provincial schemes, and there is at present wide variation in their terms as among the several provinces.

Only one great social security measure is entirely a dominion government scheme—that is, unemployment insurance.

Three of our other major measures are administered by the provinces under co-ordinating federal direction and with the assistance of substantial federal grants-in-aid, namely, Old Age Pensions, Pensions for the Blind and Vocational Training.

Unification of those six measures, all of which are included in the Beveridge plan, is not a project which can be carried out by the sole action of the national parliament of Canada.

When we come to consider the additional services that would be required in Canada to bring us to the stage envisioned by the Beveridge Report, we have to recognize that the existing system of social security in Canada upon which Beveridge's single unified structure would have to be erected is by no means so broad as that which has been developed in the United Kingdom.

Following is a brief summary of the social security measures discussed in the Beveridge Report with a note as to existing and constitutional position with regard to each:—

Unemployment Insurance

United Kingdom—National Plan in operation. Contributory.
Canada—National Plan in operation. Contributory.

Health Insurance

United Kingdom—National Plan in operation. Contributory.
Canada—Not adopted. Assumed to be in Provincial jurisdiction.

Old Age Pensions

United Kingdom—Two National Plans in operation; one non-contributory, the other adopted in 1940, contributory.

Canada—Federal-Provincial Plan in operation. Administration by Provinces, supported by Federal subvention. Non-contributory.

Pensions for Blind

United Kingdom—National Plan in operation. Non-contributory.
Canada—Federal-Provincial Plan in operation. Administration by Provinces, supported by Federal subvention. Non-contributory.

Workmen's Compensation

United Kingdom—Statutory obligation upon employers without state assistance; non-contributory as to employees.

Canada—Provincial Plans in operation. Contributory.

Mothers' Allowances (for Maintenance of Young Children)

United Kingdom—National Plan of pensions for widows and orphans. Contributory (1940 Act).

Canada—Adopted by most Provinces. Non-contributory.

Widows (Other Than Mothers of Young Children)

United Kingdom—National Plan of Pensions. Contributory (1940 Act).
Canada—No legislation. Assumed to be in Provincial jurisdiction.

Maternity Benefits

United Kingdom—Medical assistance under Health Insurance but no cash benefits. Contributory.

Canada—No legislation. Assumed to be in Provincial jurisdiction.

Family Allowances

United Kingdom—No legislation.

Canada—No legislation. Assumed to be in Provincial jurisdiction.

Death Benefits

United Kingdom—No legislation.

Canada—No legislation. Assumed to be in Provincial jurisdiction.

Thus we see that of the three main fields of social security legislation, namely,—

Insurance against the fear of unemployment;

Insurance against the fear of an impoverished old age;

Insurance against the fear of the heavy economic burdens of sickness and ill health—

Canada has legislated only with respect to the first two. The third, Health Insurance, is unquestionably the greatest present lack in Canada's system of social security and, when you consider the widely different bases upon which our existing health services, largely provincial and local, have been developed in Canada, the problem of welding them in a single scheme of national health insurance is seen to be by no means simple.

Nor is there, at this stage, certainty and agreement among those most deeply interested as to the wisest and most effective method of procedure.

In considering, therefore, how the Beveridge Plan could be applied to Canada, we must recognize two facts:—

1. We have a small foundation to build on, and, therefore, a much greater task ahead than faces Great Britain.
2. We have a complex constitutional problem, the solution of which affects the most delicate susceptibilities of our people.

This constitutional problem confronts us, not only with respect to any proposal for unification of our existing social services, but with respect to the additional services not yet covered by legislative enactment either of the dominion or of the provinces.

If we are to accept the Beveridge report as a guide to the task confronting this select committee of the House of Commons, I would say that we have three problems before us:—

1. The practical and constitutional problems of unification of our existing social services and pension schemes;
2. The additional measures necessary to give us a complete coverage of the various hazards;
3. A survey of the adequacy of the rates of benefit under our existing schemes.

Dealing first with the practical, as distinguished from the constitutional aspect of unification of existing services, this Committee might profitably institute enquiry on the following points:

What measures would be necessary to unify the several Provincial Workmen's Compensation schemes and systems of Mothers' Allowances?

What measures would be necessary to combine in one plan the treatment benefits accorded by Workmen's Compensation and Health Insurance?

What measures would be necessary to combine in one plan the cash benefits under Workmen's Compensation and Unemployment Insurance?

What measures would be necessary to adopt a single system of collecting contributions for Unemployment Insurance, Workmen's Compensation, Health Insurance and Old Age Pensions?

Under the second heading, this committee might institute enquiries as to the need, the cost and the best method of augmenting Canada's existing social security measures by the various benefits covered in the Beveridge report, such as Health Insurance (with respect to which a comprehensive report has already been prepared for the consideration of this Committee), Maternity Benefits, Death Benefits, Widows' Pensions, and Family Allowances.

We might profitably also consider how best to proceed about converting our present Old Age Pension plan into a contributory scheme.

We might institute an enquiry into the best method of putting Pensions for the Blind on a scientific basis, having greater regard for the medical treatment factor. In this connection again much useful departmental work has been done, and I hope to be able to lay a report before this committee later on.

The third heading for our researches in this Committee is as to the adequacy of our existing rates. This would involve a scientific study of the elements of a minimum subsistence standard. I would suggest that such a study should, on account of the fluctuating value of the dollar, be related to the concrete elements of subsistence, rather than to their monetary value. It would be of advantage if the system of measurement could be keyed to the existing well established "Cost of Living Index", so that periodical variations in the price level could be followed through a well understood standard of measurement.

Then again, having regard to the wide variations in climate, natural resources and social conditions in various parts of the country this study might take into account the differing requirements of residents in the maritime provinces, Quebec, Ontario, the prairies and British Columbia.

Account might be taken of the varying nutritional requirements of working adults, children and the aged.

Account might also have to be taken of the comparative rigidity of the rent factor in subsistence; and of the wide difference between rents in urban communities and in semi-rural environment.

This is a problem that Sir William Beveridge deliberately put to one side without attempting to offer a solution.

The value of such a study in determining the correctness or otherwise of our existing various scales of grants, allowances and pensions under Canada's present social service legislation needs no emphasis, if we are to try to put our whole social security system in Canada on a comprehensive and adequate basis.

Then lastly, if we are to consider the question of unification we should have to face up to the constitutional problem that would be involved, both with regard to the security measures now in effect and with regard to those that will be required to fulfill our objective of complete coverage. In this connection, however, we should not overlook the possible advantages of further development of the technique of federal grants in aid, as already employed in connection with old age pensions.

The ultimate constitutional solution, if changes are deemed to be required, would probably be beyond the powers of this committee to recommend, except in a purely suggestive way. Constitutional change of major importance would probably have to be the subject of a Dominion-Provincial Conference. The task that confronts us is thus exceedingly broad and complex.

If we were starting from scratch, we might seek in Canada to establish all our social security measures under one authority, with one single contribution, and one central administration.

Or, if we already had a complete coverage of the social security field by partly dominion and partly provincial legislation, we might with advantage have a constitutional conference with a view to determining whether or not we could agree upon unifying the existing structure.

As it happens, we are not in either of the positions that I have described. We have only partial coverage of the field, and the administration is divided between the dominion and the provinces.

Unity and simplicity of administration are ideals at which we should aim. The advantages are too obvious to need emphasis.

Unification, however, presents far greater problems in Canada than in Great Britain, and will take much longer to achieve.

The ground that I have just described as having to be covered if Canada is to adopt anything like the full scheme called for in the Beveridge plan was referred to the Committee on Reconstruction by myself, with the request that a survey be made.

The results of that survey are contained in the useful and informative report written by Dr. L. C. Marsh, which I tabled at the outset of my remarks.

It is hoped that this report may serve as a means of giving direction to the further and more exhaustive studies which would undoubtedly be necessary as a foundation for legislation.

If we are to do something practical and useful for the people of Canada quickly and effectively, it may be more to the point if, for the time being, we concentrate our efforts on filling out the gaps in our existing social security system.

As has already been mentioned, the most conspicuous gap is in the field of health. Fortunately also, this is a field to which a great deal of attention has been given by this parliament, by several of the provincial parliaments, and more recently by an advisory committee of government officials reporting to the Minister of Pensions and National Health.

If we do proceed with a health program at this time, we shall not necessarily conflict with the principles laid down in the Beveridge Report. The observations of Sir William Beveridge on this subject apply very closely to Canadian conditions.

His report contemplates that the health services and health benefits shall be administered in Great Britain not by his proposed Ministry of Social Security, but by the Ministry of Health.

In his great work on "Industry and Humanity", the present Prime Minister enumerated four main fears that haunt humanity:—

1. "Where, despite willingness to work, work is not to be had."
We have legislated about that in our Unemployment Insurance Act.
2. "Where age is confronted with the alternative of poverty or dependence."
We have legislated about that with our Old Age Pension Act.
3. "Where, through sickness and invalidity, the capacity to earn is gone."
4. "Where the privation consequent upon unavoidable loss of work is aggravated by the necessity of extra outlays."

These last two are the fears which can best be allayed by a measure of health insurance coupled with the provision of health services for all.

Mr. Chairman, Part II of my remarks deals with health insurance throughout the world and Part III with Canadian developments in the health insurance field. These are purely historical reviews, and with the consent of the committee I shall place them on the record without reading them.

Health Insurance throughout the World

Insurance against the emergency of ill health is not a new conception. Historically, it appears that the pioneer in this field was the great Prince Bismarck of Germany, who launched a scheme of health insurance in the German Empire as early as 1883.

Data assembled by my department indicates that 41 countries have adopted health insurance legislation of various types. Of these, 33 are compulsory schemes, and eight are voluntary. Insofar as European countries are concerned, the figures refer to the situation immediately preceding the outbreak of war and include several countries now under Axis domination. But, within the past year or two, compulsory health insurance schemes have also been proposed in four American countries, namely, Argentina, Brazil, Columbia and Mexico.

The most complete and comprehensive program is (as might be expected having regard to its exceptional constitutional provisions), that of the Union of Soviet Socialist Republics. Russia has provided completely socialized medicine and free treatment for all its people.

In reviewing health insurance schemes in the many countries which have adopted legislation along these lines, one is impressed with the infinite variety of schemes. Some are compulsory, and some are voluntary. Some provide monetary compensation for loss of time, others provide medical services. Some insure only the head of the family, others provide in greater or less degree for dependents. While almost all of these schemes are contributory, one at least, in Russia, consists of complete socialization of the health services.

Some schemes are financed exclusively by the insured persons. Others are aided by contributions by the employer and, in a number, the state affords assistance. Most of the schemes are for the advantage only of those whose incomes are below a certain level.

Thus, in Norway, the legislation is compulsory for those with incomes of less than approximately \$1,100 a year. The insurance is carried by societies, of which only one society is permitted to exist in a given area. The insured person pays six-tenths of the total contribution required, the employer one-tenth, the commune (or municipality) one-tenth, and the state two-tenths, or one-fifth. The insurance covers only the employed person, and not the family.

The system in Sweden is voluntary but enjoys a state subsidy. Only about 1,300,000 out of a population of 6,300,000 are covered.

In Denmark, the system is part voluntary and part compulsory, and there is no contribution by employers. The latest figures indicate that approximately 88 per cent of the population including dependents are entitled to medical and hospital care.

The unique feature of the French system is that insured persons are required to pay 15 or 20 per cent of the scale of fixed charges for doctors' attendance and medicine.

In England and Wales, a notable feature of the health insurance plan is that the employer's contribution is equal to that of the employee, and, in the case of women employees, it is actually slightly greater.

In 1938, the British scheme was expanded to take in about a million young people between school-leaving age and insurable age who had not previously been covered.

In looking over the social security programs in other countries, it is noteworthy that three of what are commonly considered to be the most progressive countries in the world are not amongst the most advanced in the field of social legislation. These are the United States, Canada, and Australia.

In considering this fact, one observes two common factors which may have had a bearing upon their apparent slowness in adopting social security legislation.

All three countries belong in what we call the New World.

The psychological attitude of our people is different from that of the inhabitants of crowded Europe.

In that stormy continent are assembled in dense masses peoples of a single language and culture who view with suspicion and enmity peoples of other language and race who surround them. Centuries of warfare have imbued these peoples with a sense of mutual responsibility to each other and, perhaps, an exaggerated sense of nationality. Most of the countries to which I refer, and especially those in which social security has been highly organized, are heavily industrialized.

War has taught them a sense of mutual interdependence which engenders a psychology receptive to co-operative measures of social security.

The lower standard of living in many European countries, as compared with the New World, and the consequent destitution when ill health visits a family are other factors which have compelled attention to the need for the social insurances.

Then again these Old World countries are administered by single national governments.

Canada, the United States and Australia have federal constitutions in which responsibility is divided between the central national government and the several state or provincial governments.

These three countries, otherwise very enlightened and progressive have been faced with constitutional difficulties in developing social legislation with which Canadians have, in the past few years, become thoroughly familiarized.

It has been commented by various observers that the peoples of the New World have a youthful and adventuresome mentality. Their eyes are focussed upon the bright star of opportunity, rather than upon the friendly glow that emanates from the domestic fireside of comfort and security.

Until the depression of the 30's, there was little popular demand for social security legislation in Canada, and this was, broadly speaking, true of the United States and Australia.

Even New Zealand is not an exception. The admirable Social Security Act of that dominion is recognized to-day as one of the most advanced and comprehensive system of its kind to be found anywhere in the world. Yet, despite the fact that New Zealand had no such constitutional difficulties as exist in Canada, Australia and the United States, the New Zealand measure was adopted only in 1938.

But there is no doubt that public opinion in the New World with regard to social legislation has changed and progressed rapidly in recent years.

In the United States, under the benign influence of President Roosevelt, there has been developed a scheme of federal subsidies for state measures of unemployment insurance, health insurance, old age pensions, and other schemes for the protection of the under-privileged.

New Zealand has acted, and Australia, heading towards the same goal, is striving vigorously to overcome the constitutional obstacles that stand in the way.

Here, in Canada, with a simple stroke of the knife, we cut through one of our constitutional difficulties and inaugurated unemployment insurance. Latterly, we have been wrestling with the problem of how best to meet the unquestioned public demand for a national scheme of health insurance, and the proposals now to be elaborated are the result of that effort.

Canadian Developments in Health Insurance Field.

The first definite approach to the subject of health insurance by any Canadian legislative body of which departmental inquiries have found record was in the province of British Columbia, in 1919, when, as the result of an extended debate in the legislature, a commission was appointed to investigate the subject. This commission recommended a state system and went so far as to outline a plan.

In 1928, there were renewed manifestations of interest, both in the provincial legislature of British Columbia and in the Dominion parliament.

In the province, this took the form of a proposal for a house committee to study the problem further. In 1929, there was another inquiry by a Royal Commission with respect to health insurance and maternity benefits.

This commission published two reports, the second and final one dated in 1932.

By 1934 the government had completed a draft bill which was published in 1935 and, with improvements, enacted as a provincial statute in 1936.

This act has never been brought into operation, chiefly due to the fact that the medical profession objected to certain features of the act and declined to co-operate.

Alberta also appointed a commission of members of the legislature in 1932 and on their report a bill was introduced and passed in 1935. For a variety of reasons this act also has remained a dead letter on the statute books.

Saskatchewan did not go quite so far as Alberta and British Columbia, but in 1934 set up a Health Service Board under whose auspices a number of progressive health measures, including free institutional treatment for tuberculosis, have been adopted.

It has already been mentioned that there was a pronounced stirring of interest in the federal field in 1928. In that year the House of Commons Standing Committee on Industrial and International Relations was instructed to make a thorough review of the subject.

The committee came to the conclusion that health insurance itself is constitutionally within the scope of provincial rather than federal jurisdiction, but recommended that the newly created Department of Pensions and National Health be requested to initiate a comprehensive survey of the field of public health with special reference to a national health program.

It was in that same session that the department as at present constituted was created by statute—the Department of Pensions and National Health Act. Part II of the act, the part dealing with health services, defines as one of the duties and powers of the minister:—

Co-operation with the provincial, territorial and other health authorities with a view to the co-ordination of the efforts proposed or made for preserving and improving the public health, the conservation of child life and the promotion of child welfare.

The assumption all along in Canada has been that health insurance is constitutionally a matter with which the provinces would have to deal. This is strikingly revealed by the fact that two provinces have already adopted legislation.

However, there is a strong public feeling that, to be successful, health insurance should be on a national basis and in 1935 the Bennett government made a serious effort to assert federal jurisdiction.

Parliament in the session of 1935 enacted the "Unemployment and Social Insurance Act," which provided directly for a national system of contributory unemployment insurance. It also authorized the administrative commission to assemble information concerning a plan for providing sickness benefits on a co-operative or collective basis whether by insurance or otherwise.

The references to national health are to be found in Part IV of the act, as follows:—

It shall be the duty of the commission

(a) to assemble reports, publications, information and data concerning any scheme or plan, whether a state, community or other scheme or plan for any group or class of persons, and whether in operation or proposed, in Canada or elsewhere, of providing, on a collective or on a co-operative basis by means of insurance or otherwise, for

(i) medical, dental and surgical care including medicines, drugs, appliances, or hospitalization, or

(ii) compensation for loss of earnings arising out of ill-health, accident or disease;

(b) to analyse and make available to any province, municipality, corporation or group of persons desiring to use the information so assembled for the purpose of providing such benefits or any of them; and

(c) as far as may be found practicable so to do on request by any province, municipality, corporation or group of persons, to examine and report on any such scheme or plan proposed to be put into effect or in effect at the date of such request, and to afford technical and professional guidance in regard to the establishing, working or reorganization of the scheme or plan.

While the language of the section contains a direct reference to health insurance it is doubtful that the powers conferred upon the commission were any broader than those already conferred upon the Minister of Pensions and National Health in the act of 1928 already referred to.

They were simply powers of enquiry and co-operation with the provinces.

It is fairly clear from the debates on this bill that it was the government's intention that if unemployment insurance stood up to the constitutional test in the courts and its operation proved a success the Dominion would in due course move on into the field of health insurance.

Actually no scheme of unemployment insurance went into operation under this act, because before administration had been set up the act was referred to the Supreme Court of Canada for a ruling as to its constitutionality.

By a majority of four to two the court held that the act was ultra vires the parliament of Canada. This decision was later upheld by the Privy Council. The reasons given are of great importance at this time when consideration is being given to the subject of health insurance.

The Bennett legislation provided for a contributory system in which the worker, his employer and the state would each bear a share of the cost, the worker's share to be obtained by pay-roll deduction.

Many arguments were advanced in the court as to the constitutionality or otherwise of the act, but the judgment is based solidly on one vital point. It is not necessary to quote voluminously from the reasons for judgment because the editor of the Canada Law Reports has stated the point with admirable clarity and conciseness in his headnote, which is, in fact, merely a condensation of the actual language of one of the Supreme Court judges. I quote from the headnote:—

The effect of the act under submission is to attach statutory terms to contracts of employment, and its immediate result is to create civil rights as between employers and employees. The dominion parliament can not use its powers of taxation to compel the insertion of contributions of that character in ordinary employment contracts.

The significance of this judgment in relation to health insurance can be more conveniently discussed when later we come to consider other aspects of the constitutional question.

The government of the day bowed both to the judgment of the courts and to public demand for a measure of national unemployment insurance. An amendment to the B.N.A. Act was sought and obtained and to-day we have this great social security measure in operation in the Dominion of Canada.

Health insurance has been debated in the House of Commons on several occasions, notably in 1939, when two very informative speeches were made, one by my predecessor as Minister of Pensions and National Health, now the Minister of National Defence for Air, the other by the member for Toronto-Greenwood. The minister dealt with the systems of insurance in effect in other countries, to which reference has already been made, and outlined the constitutional difficulties which exist in Canada.

The member for Greenwood placed before the house a review of the health of Canada and made an eloquent plea for a national preventive program. I mention these two addresses in particular because they were not delivered by medical men. They are indications of the awakening of public interest in the subject of health among others as well as those having a definite professional knowledge of the problem.

Then I come to Part IV, Preparation of Present Proposals:—

Preparation of Present Proposals

Pursuant to the recommendations of the House of Commons Committee on Industrial and International Relations in 1928, the health officers of the Department of Pensions and National Health have made it their business to conduct a more or less continuous study of health insurance ever since that date. The former minister who spoke on the subject in the house in 1939 stated that his factual information was obtained as a result of those studies.

When I came into the department and learned at first hand of this work, I was intensely interested. As a young man, I took a lively part in Scotland in those strenuous election campaigns at which the people of Great Britain endorsed the pioneer social insurance measures forever associated with the name of David Lloyd George. The desire to advance measures of this type for the betterment of the condition of the people was the spur that directed my steps into the path of public service. When, in 1939, I found myself responsible for the administration of a department in which active planning for health insurance was being carried on, I gave my strongest support and encouragement to those efforts.

This was the very period at which we were preparing our unemployment insurance measures, and I was aware of the strong public desire for a real program of reform in the public health field.

About a year ago, the departmental studies had reached a point where it was considered advisable to reduce our information to some definite formula for practical consideration.

Accordingly, on February 5, 1942, the government by Order in Council authorized the formation of an Advisory Committee on Health Insurance, consisting of appropriate officers of several departments and presided over by the Director of Public Health Services.

The instructions given to the committee were specific. His Excellency the Governor in Council directed and ordered—

That the Health Branch of the Department of Pensions and National Health under the direction of the Director of Public Health Services shall continue the study of health insurance with a view to *formulating a health insurance plan*;

That for the better carrying out of said purpose there shall be a special committee to be known as the Advisory Committee on Health Insurance; and

That the duties of the said committee shall be to study all factual data relating to health insurance and *report thereon* to the Minister of Pensions and National Health.

The committee was appointed, it worked throughout the year, it carried out its instructions to formulate a plan, and it reported the plan to the Minister in January of this year.

That plan is embodied in the proposals now to be submitted for consideration and action.

The committee did not work in a back room. It reached out into the country, and it sought the advice of a great variety of organizations and institutions considered likely to have a direct interest in this important subject.

There was a consultation with the Dominion Council of Health, which passed a resolution endorsing health insurance.

There was also a conference with the provincial Ministers of Health at which the committee's tentative proposals were explained in some detail. The explanation indicated quite definitely that the provinces would be expected to assume a portion of the cost. Nothing could be more unfair than to suggest that the provincial representatives in any sense committed themselves to any particular scheme or policy, but the committee was encouraged by the fact that no criticisms or objections were voiced at this time, nor in any subsequent correspondence. On the contrary, there has been a certain amount of unofficial co-operation from some of the provincial authorities since that time.

Other organizations were invited to form committees to make representations and consult with the government's Advisory Committee. Just to show how thoroughly the inquiries were conducted, let me list the organizations which were consulted:—

- The Canadian Medical Association
- The Canadian Dental Association
- The Canadian Pharmaceutical Association
- The Canadian Hospital Council
- The Canadian Nurses' Association
- The Catholic Hospital Association
- The Canadian Public Health Association
- The National Council of Women
- The Catholic Women's League
- The Federated Women's Institutes of Canada
- The Federation of French Canadian Women
- The Canadian Welfare Council and Canadian Association of Social Workers
- The Trades and Labour Congress of Canada
- The Canadian Federation of Agriculture
- The Canadian Manufacturers Association
- The Canadian Life Insurance Officers' Association.

The great majority of these organizations made direct recommendations, and the draft bill which has been evolved reflects to the uttermost possible practical extent the viewpoints of these important and representative groups.

Perhaps the culminating achievement of the committee, aside from the draft proposal which constitutes its report, was the unprecedented assembling between annual conventions for the first time in 75 years of the general council of the Canadian Medical Association in Ottawa, on January 15, when this great and influential body, formally went on record in favour of the principle of health insurance. That decision was not reached until after the members had familiarized themselves quite thoroughly with the general principles of the committee's report. The resolution is not to be interpreted as an endorsement of this or any other specific plan. The Medical Association reserved its right to comment on any particular provisions, but it was nevertheless a great milestone in the path of progress in Canada when the medical profession of Canada, through its general council, formally pledged itself to the principle of health insurance.

In the circumstances, the resolution is indeed an inspiring tribute to the Advisory Committee presided over by Dr. Heagerty, for, had the main principles of the proposal as outlined to the meeting by Dr. Heagerty not been in line with the high standards of the medical profession, no such resolution could, or would have been adopted and published.

Considerations leading to the form of the Advisory Committee's Proposals

The Advisory Committee in its study of the broad subject of health insurance was led to certain conclusions which are reflected in its proposals.

While these major conclusions are not expressly stated in any report by the committee, they are inherent in the nature of the plan recommended. It will be helpful if these principles are now indicated in definite language and some explanation given.

The six principles underlying the plan may be stated concisely as follows:—

1. That no scheme of health insurance can be successful without a comprehensive public health program of a preventive nature.
2. That a real health program as distinguished from a policy of cash benefits can be effective only if it embraces the entire population.
3. That the principle of compulsory contributions should be embodied in any plan of health insurance to the greatest possible extent.
4. That public opinion and efficiency demand to the greatest possible extent a national plan.
5. That the constitution, as at present understood and interpreted, prevents the dominion parliament from adopting a single comprehensive national Health Insurance Act.
6. That, for practical reasons, a constitutional amendment is not desirable.

Preventive Program

Dealing with the first principle, namely, that no scheme of health insurance can be successful without a comprehensive program of a preventive nature, I am impressed with the debates which have been heard year after year in the Parliament of Canada upon the need of more aggressive public health measures.

There are three reasons why this type of legislation is advocated.

First, the human impulse to relieve and minimize human suffering.

Second, the national economic need of a healthy population, or, to express it in a negative way, the national need to eliminate the economic waste arising from ill health.

Third, the social motive—the desire to relieve the people of the crushing burden of sickness in the home.

The only method by which the state can approach any or all of these aspects of the problem is basically financial. Any provision for relieving distress, for eliminating waste, or for lightening the burden upon the individual of the cost of medical services involves a cost. The greater the number of people to be assisted, the greater will be the cost. It follows, therefore, that the state agency which is going to assume this cost must exert every effort to diminish the weight of the financial burden.

There is abundant statistical and practical evidence to prove that preventive measures actually reduce the amount of sickness. The use of toxoid in the cities of Ontario had almost completely stamped out diphtheria before the war. The extension of free institutional treatment for tuberculosis has greatly lowered the incidence of that disease. Vaccination has reduced smallpox from plague proportions to the point where a case of smallpox in a city is front page news. Typhoid fever has become almost extinct due to proper treatment of municipal water supplies and pasteurization of milk. "Safety First" policies in industries have reduced the accident ratio. It is not necessary to multiply illustrations.

These very simple and well known facts are enough to demonstrate that well conceived preventive measures are capable of reducing the incidence of sickness and thereby lightening the cost of health insurance.

It is proposed that there should be attached to the dominion act a list of six specific types of preventive health measures with respect to which the dominion is prepared to enter into agreements with the provinces for the purpose of encouraging the adopting of an aggressive public health program.

These are in addition to the main health insurance grant and the public health grant for the provision of general health services.

The six additional types of preventive measures with respect to which it is proposed that the dominion government should make direct grants to the province are as follows:—

1. The provision of free treatment for all persons suffering from tuberculosis, including the construction of additional buildings and bed accommodation.
2. The provision of free treatment for persons suffering from mental illness and the care of mental defectives, including buildings and accommodation.
3. The provision of preventive and free treatment for persons suffering from venereal diseases.
4. The provision of training facilities in public health work for physicians, engineers, nurses and sanitary inspectors.
5. The undertaking of special investigations concerning public health or public health measures.
6. The establishing and undertaking of a program of physical fitness development for youth.

In all of these cases, the need for any particular measure would have to be approved by the dominion, and the arrangements for carrying out such measures would have to be subject to dominion approval.

As has been mentioned, these six schemes are optional, but, in order to obtain assistance towards health insurance, the province must qualify for what is called the public health grant by maintaining health services covering some twenty-four subjects enumerated in Schedule A to the model provincial bill. These are:—

Standard preventive measures for the prevention and treatment of communicable disease.

The provision of expert advisory services.

The adoption of a program of public health education through local voluntary agencies.

A mental hygiene program.

The establishment of control services with respect to communicable diseases.

The sanitary supervision of premises.

The establishment of nutritional services.

The maintenance of public health laboratories.

The establishment of sanitary engineering services.

The collection and dissemination of vital statistics.

Supervision of hospitals and sanatoria.

The provision of dental inspection for children.

The adoption of child and maternal hygiene services.

The supervision of sanitation and health environment in industry.

Quarantine inspection to prevent the introduction of communicable diseases into the province.

Provision of public health nursing services.

Adoption of health regulations with regard to housing.

An adequate venereal disease program.

A program for the prevention, detection and treatment of tuberculosis.

Cancer clinics.

Preventive and diagnostic services for the early detection of heart disease in children.

Medical inspection in the schools.

Investigations of epidemics.

Research services.

All of these services exist in greater or less degree in some of the provinces, but it cannot be said that all of them exist in all the provinces. Only by a comprehensive approach to all of these various problems can we keep the cost of health insurance within reasonable limits.

Entire Population—

The second principle upon which this plan is founded is that it must cover the entire population.

We are dealing here with a health program. Our basic and fundamental purpose is to improve the health of the people through reduction of the incidence of disease and death and by creating positive health. Measures which are directed only to one portion of the population will fail if some other group of people nearby are permitted to neglect the precautionary measures required of the first group.

There are two main types of benefits associated with the idea of health insurance. One type gives cash benefits as compensation for loss of time through sickness. The other gives direct medical service. If we were dealing with cash benefits, there would be an obvious argument for limiting these to certain groups of comparatively small wage earners. But, if an epidemic invades a community, the bacteria do not knock only at the doors of those earning less than \$1,800 a year. The next door neighbour with an income of \$5,000 a year has no divine right of immunity by reason of his income, and a rich man can carry disease germs just as effectively as a poor man.

If we are to protect the poor people from ill health we must require observance of health rules from the entire population.

Since our fundamental purpose is the improvement of the health of the people, we feel that this proposed legislation must apply to everybody.

Nevertheless, if, for reasons which at the time appear to be sound, any province in submitting its legislation to the dominion for approval finds it impracticable to cover the entire population, it is recommended that the dominion should not be debarred from granting assistance.

There is another reason why our legislation should cover everybody. Economic and social conditions vary in the several provinces. If we were to apply a limit in the model provincial bill, it would have to be a single standard limitation. What would be a suitable limit in New Brunswick or Saskatchewan might be totally inapplicable to Ontario or British Columbia. Since there can be no standard and uniform limitation, it is better that the dominion should adopt the basic assumption that all may benefit, leaving it to the individual provinces to determine whether or not certain classes could or should be excluded. In any event, the health ideal calls for total coverage.

Contributory System—

The third basic policy embodied in this proposal is the contributory principle.

The modern trend throughout the world with respect to all forms of social insurance is that they shall be contributory. This is based upon several considerations.

The first is that a completely free or non-contributory system may encourage the pauper mentality; may lead to a delusion that the public purse is bottomless.

Another consideration supporting the idea of contributions is that it is more consistent with the dignity and independence of a man that he shall be enabled to apply for something that he has purchased with his own effort. Under a contributory system, benefit becomes a right and not a concession.

A third reason for direct contributions is that the individual beneficiaries are kept in touch by their contributions with the actual cost of the services they receive.

If, for instance, our hopes should be fulfilled and the health of the community is greatly improved, there should be some reflection of this in reduced contributions.

On the other hand, if people needlessly run to the doctor and overburden the services, this is bound to be reflected in increased costs, which will, in turn, be reflected in increased contributions.

A contribution thus has a deterring effect against abuses of the system and will encourage a sense of responsibility on the part of the citizen towards the whole administration of health insurance.

Indeed, a health insurance plan without contributions would not be an insurance scheme at all; it would simply be a system of free health benefits. It is the very essence of insurance that the person who hopes to benefit shall pay a premium supporting the financial plan which provides the benefits.

In this proposal, we are insuring not merely the individual against the hazard of his own sickness. We are insuring industry against the tremendous waste of loss of time and efficiency that comes from ill health, and we are insuring the community as a whole against the debilitation and economic burdens of ill health. At no time is the value and importance of national health more obvious than in the midst of war. I emphasize the word "obvious"—because I am convinced that ill health handicaps the accomplishments of our national purposes just as greatly in times of peace as in times of war.

Hence, while the individual should be called upon to pay according to his means for the health services that he is to receive, there is a real return to the country from any contribution which is made to the cause of national health out of the general public purse.

Industry also has a definite stake in the health of our working population. It has been estimated that every day fifty thousand workers are absent from

their places in the factory and the office on account of ill health. Constant adjustment of duties represents a factor of inefficiency against which industry can protect itself by improved health measures.

There is a further reason why some portion of the cost of the insurance of employees should be borne by the employer. Every man or woman who works for wages spends approximately one-third of his or her time in an environment created or dictated by the employer. That environment may be healthful or otherwise. The obligation to make a contribution towards the cost of sickness encountered by employees will give an incentive to the employer to safeguard the health of his workers.

The advisory committee recommends not merely a health insurance bill—it is a health bill—a bill that is designed to do constructive work in raising the positive health standard of the people of Canada.

National Plan—

The fourth principle recognized by the committee is that public opinion favours a health insurance programme that shall be nation-wide in its scope and operations.

I think if we compiled all the resolutions that have been passed in Canada to that effect in the past twenty years they would fill a volume of *Hansard*. My department has been hammered and pounded all through the years to initiate a national health program.

When, in 1919, the late Chief Justice Rowell introduced his legislation for a Department of National Health, his purpose was to develop to the highest degree possible a health program upon national lines. The same policy was expressed when, in 1928, the Department of Pensions and National Health Act was adopted.

The House of Commons committee of that year emphasized in its report that more must be done in the public health field upon national lines.

When the present government, a year ago, instructed the Advisory Committee on Health Insurance to draw up and recommend a plan, it was not thinking of a program of which this government should wash its hands and say this is a matter purely for the provinces. Our purpose was to go as far as we possibly could through the powers that this parliament possesses.

In its comprehensive references to social security and health insurance, the recent convention of the Progressive Conservative party in Winnipeg emphatically asserted that the state's share of the cost of these security measures should be borne by the dominion.

The Leader of the Cooperative Commonwealth Federation in his able broadcast review of the policies of that party on January 22 indicated very clearly that his movement regards the responsibility for initiating a security plan as devolving upon the national government.

But beyond these manifestations of the state of public opinion there are practical and technical reasons why health insurance should be approached from the national standpoint.

The first thought that will occur to most of us is one with respect to which this country has already had experience. If any one province adopts an advanced and expensive reform, it imposes a burden of taxation which is considered to involve a handicap upon the industrial life of that province in competition with other provinces. Provincial governments with the most enlightened and progressive views and policies have hesitated to handicap their industrial development by costs which their competitors in other provinces escape. Canada went all through that in connection with workmen's compensation and old age pensions. It is a bold province that will be the first to take the plunge. We have seen Alberta and British Columbia adopt health insurance acts and refrain from proclaiming them.

Behind all the other reasons advanced for their failure to bring them into operation is the undoubted fear of industry in those provinces that they would suffer competitively.

Thus the reluctance of individual provinces inevitably throws to the dominion the responsibility of taking the initiative.

If health insurance is to be considered as a public health measure—which it is—there is another reason for national action. Epidemics and disease-breeding conditions do not stop at provincial border-lines. The tremendous increase in our transportation facilities is tending steadily to increase the amount of travel. There is no doubt in my mind that certain eccentricities in our vital and morbidity statistics during the past year or two are to be accounted for very largely by the continual movement of members of the armed forces and their families from province to province, and from town to town.

For the past decade, there has been a progressive improvement of the public health as reflected in these statistics, and, while that improvement was not seriously retarded in 1941 and 1942, there were upward curves in one or two classifications of disease and in several localities that are probably to be accounted for by the factor of increased movements of population and the carrying of infection. And with all the technical improvements in travel facilities—more and better roads—more and cheaper motor cars, lighter and faster public conveyances including aircraft—the movement of people from place to place is going to continue to increase.

The health of Canada is, therefore, one single problem, and we cannot break it up into geographical segments.

Constitutional Question—

There would be no need to emphasize this demand for a national program—it would be self-evident—but for the fact of which we are all aware, that our present constitution stands in the way.

If we assume, for instance, that health insurance ought to be on a contributory basis—and the committee has so assumed—then we are faced at once with the decision of Privy Council and the Supreme Court of Canada on the case of the Unemployment and Social Insurance Act of 1935. The dominion cannot create civil rights as between employer and employee.

That was fatal to unemployment insurance until we amended the B.N.A. Act, and it is fatal to national health insurance if we are to have a contributory plan.

But the constitutional difficulty in the way of health insurance is even greater than it was with regard to unemployment.

It is conceded that the B.N.A. Act is somewhat vague in its reference to the field of public health. This arises from the fact that many of the types of health service now in practical operation were never envisioned at the time the fathers of confederation performed their monumental task.

In consequence, there are differences of opinion among constitutional authorities about how this portion of the act should be interpreted. On the other hand, there has been little dispute about the rights of the dominion and the provinces to adopt the measures which they have respectively developed throughout the years.

For instance, the provinces control the regulation of the medical profession. Each province has its statute setting up a medical council or medical college with the right to license practitioners and to discipline and regulate their activities.

Our hospitals have grown up as provincial and municipal systems. Mandatory legislation with regard to health measures, affecting the rights of the person, are clearly in the scope of provincial jurisdiction. My predecessor, the present Minister of National Defence for Air, in debating a resolution recommending compulsory medical examinations in 1939, pointed out that the dominion govern-

ment had no right to impose compulsion for such examinations, that this was clearly a power of the province under "civil rights".

Any attempt by the dominion to exercise powers along these lines would be brought up short in the courts. And it is very doubtful that we could have health insurance or a sound and practical public health program without trespassing on one or all of these fields.

Sirois Recommendations Followed—

It can be argued, of course, that we should brush all these difficulties aside by constitutional amendment.

The Advisory Committee on Health Insurance has come to the conclusion that this should not be attempted. For one thing, I doubt that the problem of constitutional action is by any means as simple as it was in the case of unemployment insurance, because in that field we were not taking over any established institutions of the provinces. Health insurance, as has been indicated, would involve a series of steps that cut right across existing provincial statutes and provincial customs and practices of long standing.

In considering whether or not it would be wise to attempt a constitutional amendment, we have the benefit of some very sound and well considered advice in the report of the Royal Commission on Dominion-Provincial Relations, whose first chairman, you will recall, the late Chief Justice Rowell, was one of our greatest constitutional authorities.

Let me quote some of the observations of the Commission in Book II of its report, the volume containing the Commission's Recommendations:

P. 13. "In devising the most appropriate allocation of jurisdiction in the light of present conditions and probable future developments, the Commission has been guided by the following considerations:—

- (a) the presumption that existing constitutional arrangements should not be disturbed except for compelling reasons;
- (b) existence of pronounced differences in social philosophy between different regions in Canada;
- (c) the need for economy and efficiency in administration;
- (d) the suitability of different jurisdictions for carrying the financial burdens involved."

P. 13. "We emphasize . . . the importance of limiting the transfer of jurisdiction to the dominion of what is strictly necessary."

P. 14. "Co-operation (between dominion and provinces) is becoming increasingly desirable, especially in those functions which tend to straddle the division of powers between the dominion and the provinces, if provincial autonomy is to be preserved and efficiency in government at the same time achieved."

P. 34. "We cannot see that it would be practicable to assign public health exclusively either to the dominion or to the province."

P. 34. "There are pronounced regional differences in Canada in social philosophy which are bound to affect public health legislation. Centralization of jurisdiction might not, therefore, conduce to progressive action in public health, or to national unity in general . . . We think therefore that the present jurisdictional situation should not be disturbed."

Later on, after reviewing the health functions which the dominion and the provinces are now carrying out and laying down its views as to how these divided functions should be further developed, the Commission holds that the province should have the basic decision as to whether or not health insurance should be adopted, but goes on to say that the dominion should give leadership in effecting co-operation between the provinces, and on Page 44 concludes that all its foregoing observations do "not rule out the possibility of dominion assistance by grants-in-aid for particular services," such as "special health measures."

The Advisory Committee on Health Insurance has followed the counsel of the Sirois Commission closely. It has avoided a constitutional amendment, it has left primary jurisdiction where it is, it has left the ultimate decision with the provinces, it proposes leadership in co-operation and standards by the dominion, and it proposes grants-in-aid.

It will be observed that the arguments against a constitutional amendment are practical rather than theoretical. The dominion would have to take over the administration of functions with which the provinces are already dealing in a variety of methods that intimately reflect their respective historic cultures. In old Quebec, we have a hospital and eleemosynary system based upon and closely interwoven with the cherished religious institutions of its people. Next door, in Ontario, we have an entirely different system reflecting no less basically the firmly held convictions of the people of that province.

A national health program that excluded the direction and control of those institutions would be a feeble and emaciated structure. A national program must have elements of uniformity and it is neither desirable nor practicable to attempt the standardization of institutions which have developed along such widely divergent lines.

Fortunately, the committee has found another way of exercising dominion leadership, of inaugurating a plan that is national in scope and that can be assisted by national funds raised through the dominion's wider powers of taxation.

The Advisory Committee's Proposal—

At this point, it may be helpful if I describe briefly the nature of the plan which has been recommended.

Needless to say, the advisory committee contemplates a federal statute as the foundation stone of the structure.

The committee also considers that health insurance must go hand in hand with a broad program of preventive health measures. Indeed, health insurance is considered to be only the chief of a series of such measures. The primary consideration is the health of the people.

The advisory committee recommends that the dominion government be empowered to assist financially any province which enacts a health insurance measure along the lines of a model provincial bill which has been drafted.

It is provided, however, that no aid shall be given unless the province also agrees to undertake a general public health program approved by the dominion. A grant-in-aid of this program will also be given.

That is, the dominion government will assist the provinces, both with respect to health insurance and with respect to a public health program, but will not help a province with regard to either one of these projects unless both are put into effect.

The provincial scheme contemplated in the committee's recommendations is broad enough to cover the entire population, employed and unemployed, master and servant, farmer and industrialist, the working adult, the aged, the indigent and the children. Nobody need be excluded.

Nevertheless, the way is left open for a province to limit benefits to those having less than a certain income ceiling. The committee's report favours total coverage, but does not make this compulsory upon the province.

The model provincial bill is constructed upon the compulsory and contributory principles. All adults, whose wages, earnings, or incomes come within a certain formula of adequacy, will be required to pay their own contributions. The husband, if he can afford it as measured by the standard laid down, will pay for his wife, but the cost of children will be distributed over the whole contributing population.

The benefits will consist of complete medical and nursing services, hospitalization on a general ward basis, medicines within an approved list of standard remedies, and dental care, at least to the extent that existing dental facilities are capable of providing.

Cash benefits for lost time are not included in this measure. Most of our working people for whom cash benefits would be appropriate are already covered by unemployment insurance, and it would seem that, if cash benefits are considered necessary, they could best be administered in connection with that legislation.

The committee has recommended that there be two methods of collecting contributions. Under this plan the whole population will be registered, and income recipients divided into two groups to be known as employed contributors and assessed contributors.

Employed contributors, that is wage and salary earners, would pay their contributions by the familiar method of payroll deductions.

Assessed contributors are those whose income is earned as working proprietors or who derive their incomes from investment. The problem with assessed contributors is to ascertain their actual income, and a procedure for this has been incorporated in the draft provincial bill. This procedure will be explained a little later. For the moment the important consideration is that, when his income has been determined, the assessed contributor will be called upon by this scheme to pay the same amount as the employed contributor having an equal income and like domestic circumstances.

Let us therefore examine the amounts and rates of contributions in the first place from the less complex standpoint of the wage earner.

Before mentioning figures, it should be stated that exact or correct statistics cannot be foreshadowed at this stage. The proposed legislation contains a number of options and alternatives which are left largely to the discretion of the province, or to negotiation between province and dominion. It cannot be predicted which alternative the provinces will adopt, or even that all provinces will adopt the same alternative.

Financial Estimates—

Figures used by the committee in its report are based upon the general assumption that the broadest possible coverage and the maximum health services will be adopted.

The cost of illness in Canada is known. A special study was made by the Bureau of Statistics in 1935 and the figure was \$240,500,000. The committee adjusted this figure to the population of 1938, the last complete non-war year. Calculations in the report were based on that year.

To determine the average contribution which must be obtained, it was necessary to make a rough distribution of the cost of sickness for the whole population among the number of adults 16 years and over. The result is \$26.45 per capita per annum. It has been deemed both convenient and not misleading to use the round figure of \$26 a year for each adult, this number having the incidental merit that it works out at an even 50 cents a week.

This figure, it should be remembered, covers the cost of health services for all children, and the committee has recommended, for reasons which I shall later explain, that the cost of children be spread over the population as a whole. Calculations are based on that assumption.

The committee recommends that the adult wage-earner or assessed contributor shall pay the premium for his adult dependents, wives, children over 16, dependent parents, or other members of the family for whose support and maintenance the contributor has at present assumed the responsibility.

It has been assumed, however, that there will be a point beyond which parliament, federal or provincial, will not ask the small wage-earner to go.

For purposes of calculation, the committee has conjectured that parliament would not ask a man to pay the full \$26 if that sum exceeds 3 per cent of his income, and the report recommends the procedure by which the difference will be made up.

As \$26 is 3 per cent of \$866, it follows that, according to the committee's plan, a single man earning \$866 a year or more would pay his full contribution of \$26, but that a man earning less than \$866 would be asked to pay only 3 per cent of his wages, and the remainder of the \$26 would be made up from other sources on his behalf.

As in practically all health insurance schemes, a contribution from employers is contemplated, and it is recommended that the employer's contribution shall be the amount needed to make up the required \$26 after the worker has paid 3 per cent of his wages. Employers are not to be asked to make any contribution towards the insurance of those who, by the recommended standard, are able to pay their own premiums, nor will the employer be asked to make any contribution towards the insurance of wives or other adult dependants.

The wage-earner is in principle required to pay for his adult dependants, but again it has been considered that parliament will not require the small wage-earner to pay an excessive amount in relation to his income.

It was assumed, for the sake of illustration, that the married man with an income of \$1,400 ought to be able to pay the full premium for himself and his wife. At that level, the required \$52 is 3·7 per cent of his income.

Accordingly, the report recommends that a married man (or any man with one adult dependant) should be required to pay a minimum of 7/10 of one per cent of his income towards the insurance of his wife or other dependant. The residual amount is to be a charge on the public treasury, to be paid by the province. It should be borne in mind, however, that the dominion is to make a grant towards the provincial costs, so that when, in this connection, we refer to the province, we refer only to the immediate source of the contribution and not to its ultimate distribution as between province and dominion.

To take a specific illustration, the married man with an income of less than \$866 will pay 3·7 per cent of his income as his overall premium. He will pay 3 per cent as his own contribution and the employer will contribute the sum necessary to make up the \$26. He will pay ·7 per cent of his income on behalf of his wife and the province will make up the remainder of that \$26.

The man earning between \$866 and \$1,400 pays the full \$26 on his own account and ·7 per cent on his wife's account. But he will also pay on behalf of his wife the amount by which 3 per cent of his income exceeds \$26.

The man earning \$1,400 or over pays the full \$52.

To illustrate the case of the man between \$866 and \$1,400, the committee has cited the instance of a married man with an income of \$1,000.

This man pays \$26 on his own account, and the employer makes no contribution.

The 7/10 of 1 per cent for his wife is \$7. The amount by which 3 per cent of his income exceeds the \$26 which he has paid as his own premium is \$4, so he also pays that \$4. Hence, the man with an income of \$1,000 pays \$26 for himself and \$11 for his wife, or \$37 in all, leaving the province to provide the additional \$15 to make up the \$52.

Then, there are the cases of contributors with two or three dependants. The committee has assumed that a man with an income of \$1,800 might well be expected to pay the full premium for himself and his two dependants, a total of \$78, which works out at 4·3 per cent of his income.

This, it will be noted, is 1·3 per cent more than the 3 per cent accounted as the maximum contribution of a single man in his own behalf. Accordingly, the man with two dependants and an income of less than \$1,800 will be

required to pay at least 1·3 per cent of his income towards the premiums of his two dependants and, in addition, the amount by which 3 per cent of his income exceeds \$26.

Taking again the man with an income of \$1,000 and two dependants, the total contribution of \$78 will be made up as follows,—

The wage-earner—On his own account.....	\$26 00
On behalf of dependants at 1·3 per cent.....	13 00
At 3 per cent of income less \$26.....	4 00
	<hr/>
	\$43 00
Provincial government.....	35 00
	<hr/>
	\$78 00

The committee has taken \$2,100 as the income level at which a man might be called upon to pay the whole premium for himself and three dependants. In the case of the man with an income of \$1,000, the same principles would require that the man's contribution for himself and three dependants be \$49·50, and the provincial government's contribution \$54·50.

In the foregoing, I have referred to the normal domestic situation of a man and his wife or other adult dependants. The formula would apply equally to an employed or assessed woman and her dependants.

The contribution of an employed person under twenty years of age will be less than that of the adult worker by a proportion which is estimated to represent the cost of giving service to children. In other words, the cost of the benefits which are to be given to all children alike will be assessed only upon contributors who are more than twenty years of age.

There will be also an especially low rate of contributions for employed persons under the age of seventeen.

Provision for children—

Before leaving this question of contributions, a word should be said about the basis of providing for children.

We have not, in Canada, any system of family allowances or maternity benefits such as exist to some extent in Britain and has been urged for further development in the Beveridge Plan.

All the necessary medical care and hospitalization in connection with maternity will, of course, be provided in the comprehensive health services contemplated in the scheme now under discussion.

The ideal behind the granting of family allowances is to relieve parents of some of the cost of rearing large families. Children are recognized as an asset of the state as a whole, and any system of family allowances is designed to distribute the cost over the whole population and not to leave it entirely upon the family. There is no doubt that economic reasons have much to do with a low birth rate.

One of the greatest financial costs incurred in rearing a family of children is sickness. The advisory committee aims at distributing this burden over the entire community. The bugbear of measles, whooping cough and scarlet fever and these other epidemic conditions which go through whole families will no longer be an economic burden upon the father of a large family. The doctor's bill and the bill for medicines and other forms of ministration which may be called for will come out of the fund.

In other words, the parents of a family of ten will have no greater costs for sickness in the family than the childless couple.

Most health insurance schemes provide only for the employed and contributing head of the family and give no assistance to the dependants. The

scheme now proposed gives complete coverage to the entire family and distributes the cost over the community as a whole. This does not meet the whole of the case for family allowances, but it goes a long way and, should at some future date family allowance be decided upon, the cost will be proportionately less.

Assessment of Non-Wage Earners—

One of the major problems which confronts those planning any contributory measure of social insurance is how to obtain contributions from those who do not derive their incomes from an industrial payroll.

The advisory committee has offered a solution to the admittedly difficult problem of how to assess and collect from the small merchant, the worker-on-his-own, the farmer, the professional man, and the retired person living on an income, or investments, or some similar source.

The collections from this class are to be made by an annual assessment. The basis of the assessment will, in the first place, be the actual income. There are, however, others of greater or less means with respect to whom the actual cash income would not be a suitable method of assessment. The farmer is an outstanding example of this category.

It should be understood that the assessment of the owner-worker, the farmer and the professional man is to be on the same basis as that of the wage-earner which has been set at \$26 a year. The problem is to determine whether the farmer and other non-wage earner should pay his whole contribution, and, if not, to what extent he should be assisted.

The committee's proposal in this regard is that we shall obtain a statement of the man's properties, less any charges against them, and assume that these properties have an earning power of, say, 3 or 3½ per cent.

This estimated earning value of the contributor's property added to his actual cash income will be the basis of determining whether he shall pay the whole contribution, or whether the public treasury should absorb some portion of it.

The same calculations with regard to dependants will be made as in the case of wage earners. But, as there will be no employer to make up any deficiency in the contributor's own premium, any assistance in the case of assessed contributors must come from the public treasury, i.e., the province in the first instance.

Here again a difficulty presents itself as to what proportion of the contribution from the public treasury should be paid by the province and what proportion by the dominion.

In their report, the advisory committee have assumed the existence of normal financial relations between the dominion and the provinces much as they were prior to the war and particularly prior to the dominion-provincial agreements by which the dominion acquired the more flexible sources of provincial revenues for war purposes.

The committee's calculations were, for the most part, based on the year 1938 which was a pre-war year and a year in which the provinces had a very different revenue position from that which exists to-day.

If health insurance were to be adopted in the midst of the war, the financial arrangements between dominion and province would have to be based on the present revenue agreements.

If this proposal is to be adopted with the idea of its coming into effect after the war, the distribution of the financial cost as between dominion and provinces will probably have to be left to be worked out by negotiation between the governments in the light of the post-war financial arrangements which will succeed the present agreement.

This is no obstacle to whatever progress we are able to make at this time, because in any event the scheme calls for the negotiation of agreements between the dominion and each province adopting health insurance. It is recommended

that the dominion should not grant assistance to a province unless the legislation adopted by the province meets with federal approval, or, to express it in another way, unless the provincial plan comes within the principles laid down by the dominion parliament in its enabling legislation.

Distribution of Costs—

These are purely for discussion.

In the financial section of its report, the committee has worked out several bases for the dominion government's contribution, as fractions of the total operational cost of the scheme.

These fractions are one-ninth, one-eighth, one-sixth and two-ninths. The advantage of these fractions is that, by simple multiplication, we could arrive at one-quarter, one-third, or four-ninths, if any of these other formulae were considered more suitable.

On the 1939 population, the committee has shown what the dominion's contribution would be both on a per capita basis and in gross amount in three alternative formulae, namely, one-ninth, one-eighth and one-sixth, as follows:—

	One-Ninth	One-Eighth	One-Sixth
Per capita	\$2.40	\$2.70	\$3.60
Gross	\$26,901,600	\$30,264,430	\$40,352,400

Most of the tables herein are based on one-sixth.

In its various extensions and illustrations, the committee has adopted the formula of one-sixth for illustration purposes, and, since they were dealing with the year 1938, when provinces had their normal taxation powers as defined in the B.N.A. Act, possibly that was as good an illustration as any that might have been adopted.

In the event, however, of our adopting any such financial proposals as those in the Sirois Report, or of our continuing on a more or less permanent basis the war-time dominion-provincial agreements with regard to revenues, it will be of advantage to have before us illustrations based on the dominion assuming a larger proportion of the costs than one-sixth.

Let me place before the committee, therefore, the dominion grants which would be required if any of the following formulae were adopted:—

	Two Ninths	One Quarter	One Third	Four Ninths
Per Capita	\$4.80	\$5.40	\$7.20	\$9.60
Gross	\$53,803,200	\$60,528,860	\$80,704,800	\$107,606,400

These are the larger proportions, up to \$107,000,000.

The total cost of a year's operations on the known population figures for 1938 is, \$232,896,000; to which must be added the cost of administration, \$23,290,000; making a total of \$256,186,000.

The sources of revenue from which this fund is to be derived are, in the first place, contributions as follows:—

Full-time employees on own behalf	\$35,392,000
Broken-time employees on own behalf	11,403,000
Employees in behalf of dependants	16,747,000

Total employees	\$63,542,000
Employers on behalf of full-time employees . .	\$11,499,000
Employers on behalf of broken-time employees.	3,846,000
Employers on behalf of unpaid labour with living allowance (members of families of store-keepers, farmers, et al.)	8,827,000

Total for employers	\$24,172,000
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Assessed contributors—

Working proprietors on own behalf	\$19,216,000
Other income recipients with no occupation..	3,793,000
Dependents of working proprietors	12,904,000
Dependents of broken families	1,123,000

Total for assessed contributors \$37,036,000

This makes a total of contributions from beneficiaries and employers of \$124,750,000.

After the contributions have been collected, there would, therefore, remain to be made up out of the public treasury (provincial and federal) \$131,436,000.

And the rural financial problem is how that amount is to be allocated by federal and provincial authorities.

Included in the overall cost of the scheme are, however, certain expenses now borne by the province which will be absorbed by the health insurance plan. These are chiefly grants to hospitals and payments made in behalf of indigents and others unable to pay for medical treatment and hospitalization.

The committee have ascertained that this sum of existing expenditures borne by the provinces to be absorbed in the scheme is approximately 15 million dollars.

From the total sum to be included against the public purse, there should, therefore, be subtracted 15 million dollars, leaving \$116,436,000 to be met by the dominion and provincial governments.

The respective dominion and provincial contributions under the several formulæ, which I have already indicated, would be as follows:—

Dominion Grant of One-Sixth of Operational Cost

By Dominion.....	\$40,352,000
By Provinces.....	76,084,000

That is without the \$7,000,000 for public health grants.

Dominion Grant of Two-Ninths of Operational Cost

By Dominion.....	\$53,803,200
By Provinces.....	62,632,800

Dominion Grant of One-Quarter of Operational Cost

By Dominion.....	\$60,528,860
By Provinces.....	55,907,140

Dominion Grant of One-Third of Operational Cost

By Dominion.....	\$80,704,800
By Provinces.....	35,731,200

Dominion Grant of Four-Ninths of Operational Cost

By Dominion.....	\$107,606,400
By Provinces.....	8,829,600

I can give the committee the residual amounts to be made up out of the public treasury to complete the required contribution of \$26 a head for the various types of contributors who are unable to provide for their own full contributions on the assumption of the dominion making a grant of one-sixth, but I am not able at present to give a similar break-down with regard to any other formula for the dominion grant, because that is the only one which the committee has worked out in complete detail. That is the only one that is worked out in complete detail. The others could quite easily be worked out.

Assuming the dominion to have contributed \$3.60 a head for the population, or \$40,352,000 towards the total cost, the amounts to be made up by the province with respect to the various types of contributors and for the purpose of caring for indigents and administration would be as follows:—

Employees broken time.....	\$ 7,930,000	
Working proprietors.....	8,445,000	
Other income recipients.....	1,667,000	
Dependents of employees.....	16,376,000	
Dependents of working proprietors..	12,619,000	
Dependents of broken families.....	1,179,000	
Residual adult population.....	19,578,000	
	<hr/>	\$67,794,000
Administration (10 per cent of operational cost) ..		23,290,000
		<hr/>
Total.....		\$91,084,000

This information is of interest because an alternative suggestion considered by the Advisory Committee, but not included in its report, was that the dominion might contribute, in addition to one sixth of the operational cost, one third or some appropriate proportion of the amounts to be paid by the provinces for the purpose of making up deficiencies in contributions.

Assuming the dominion to have made a contribution of one sixth of the total cost, the provinces' residual grant towards making good deficiencies in contributions would be \$67,794,000.

If the dominion were to assume one third of this, the resulting charges upon the dominion and provincial treasuries would be:—

By dominion		\$62,950,000
By provinces		
Operational	\$45,196,000	
Administrative	23,290,000	
	<hr/>	
Total	68,486,000	
Less present expenditures	15,000,000	
	<hr/>	53,486,000

If one third does not prove to be a precisely suitable portion, any other fraction could be used in applying this principle, which has a special merit that I would like to mention.

There are some provinces in which the proportion of contributors unable to meet the full contributions required from them will be greater than in others.

The suggestion that the dominion meet a definite portion of this deficiency would have an equalizing effect on the whole program from a national standpoint. This is a very interesting suggestion which the members of this select committee may find it useful to consider carefully.

Still another approach to the question of how the costs should be divided as between dominion and provinces would be to take the total cost remaining to be met by the public treasuries after all contributions have been deducted from the total cost of the scheme.

As has already been stated, the total assistance from the public treasury would then be \$116,436,000. This amount could then be divided between the dominion and the provinces in equal portions or in such other proportions as might be found expedient, having regard to the ability of the provinces to meet their share.

Whatever formula may be adopted as between dominion and provinces, it will be of interest to note that contributions from employees, employers and

assessed contributors are estimated to provide 48·7 of the overall, leaving 51·3 to be made up by the dominion and the provinces from the public treasury.

The proportions from each group of contributors are as follows:—

	Amount	Per Cent
By employees	\$63,542,000	24·8
By employers	24,172,000	9·4
By assessed contributors ...	37,036,000	14·5
		<hr/> 48·7
Public Treasury (including \$23,290,000 for administration)	131,436,000	51·3
		<hr/>
Total	\$256,186,000	100·0

Grants for Health Services.

The committee has made certain suggestive estimates of the bases upon which the dominion government should make grants to the provinces for the seven recommended types of health services in addition to health insurance.

It is proposed that the public health grant, without the acceptance of which it is recommended that there should be no federal assistance to health insurance, should be at the rate of 25 cents per capita, which would aggregate \$2,872,428 divided among the provinces as follows:—

Public Health:	P. E. I.	\$ 23,762
	N. S.	144,491
	N. B.	114,350
	P. Q.	832,970
	Ont.	946,914
	Man.	182,436
	Sask.	223,998
	Alta.	199,042
	B. C.	204,465

With regard to the treatment of tuberculosis and mental diseases, it is recommended that the grant should be at the rate of $\frac{1}{9}$ of provincial expenditures. Based on existing provincial costs, this would lead to a dominion grant—

For *Tuberculosis* treatment — of \$1,035,155, and for the treatment of
Mental Diseases — — — \$2,171,485

With respect to *Venereal Diseases*, the recommendation is that the dominion grant should be at the rate of $1\frac{1}{10}$ cents per capita ($\cdot 017$) or a total federal grant of \$195,325.

It is suggested that the grants for professional training purposes and for scientific investigation should be at the need of the provinces. The committee has suggested that \$100,000 be appropriated to be available for the *Professional Training Grants* and \$50,000 for *Investigational Purposes*.

As the permanent basis of grants for a physical fitness program, the recommendation is that the basis be $2\frac{1}{5}$ cents per capita ($\cdot 022$ cents). This would make a total sum available for grants to all provinces for *Physical Fitness* of \$232,774.

The grand total of *Public Health* grants to the provinces over and above the federal assistance to the health insurance program itself would be \$6,527,167, divided among the provinces as follows:—

P. E. I.	\$ 48,717
N. S.	316,228
N. B.	212,848
Que.	2,015,076
Ont.	2,147,317
Man.	390,805
Sask.	518,239
Alta.	399,882
B. C.	478,055

This summary does not include any distribution of the proposed grant for professional training and public health investigational work, which assistance, it is recommended, should be at the need of the provinces and might be on a very uneven basis, in the event of different provinces developing specialized projects for the use of the available funds.

How Public obtain Services—

Another important feature of the Advisory Committee's recommendation deals with the manner in which the people are to obtain the service provided for. The committee's purpose has been to disturb the normal existing arrangements and customs of the people as little as possible.

As provided for in the recommended scheme, the sick person will, as now, see the physician of his choice. The family doctor may call in a specialist if necessary, and may order nursing attendance or hospitalization, and he may prescribe medicines, or other special treatment facilities.

The big difference will be that the doctor, the nurse and the hospital will send their bills to the health insurance fund instead of to the patient.

It will rest between the medical profession and the provincial health insurance administration as to whether the basis of paying the doctor shall be fees or a capitation system. Originally, the medical profession were disposed to insist upon fees. I am advised that there is now a swing on the part of the doctors towards capitation, and I would suggest that, from a public health standpoint, the capitation system is preferable, because it will encourage the physician to counsel and urge preventive measures.

As this has been left to provincial discretion, the probability is that we shall see both methods in operation and shall have a basis of comparison later on, which may lead to subsequent changes in the direction of the system that yields the greater all round advantage.

I have said that the patient will be allowed to choose his or her doctor. Provision has been made, however, for the provincial commission to organize for each administrative area lists of doctors out of which the patient may choose. These lists should, as far as possible, include a complete panel of specialists, so that full clinical service shall be available in each area to the greatest possible extent. In lieu of choosing a doctor, the insured person may prefer to select a "group clinic" and the scheme would permit this to be done.

It is also suggested that the doctor should have the same liberty of choice as the patient, and may refuse to have any particular patient upon his list.

The plan contemplates that hospital services shall be on the basis of the general ward, but, if the patient wishes to have semi-private or private accommodation, he may do so by paying the difference.

One great benefit that will accrue from this proposal is that the day of hospital deficits and hospital grants will come to an end. Every patient will be a paying patient and the province and municipality will no longer have to make good the cost of indigents and non-paying patients.

This and similar savings on existing provincial and municipal expenditures go a long way to meeting the extra cost of the provincial share of health insurance.

In the case of medicines, it is proposed that the provincial health insurance authorities in co-operation with the organization representing the pharmacists shall lay down a comprehensive list of standard medicines which may be provided free or partly free as may be indicated in the agreements between the dominion and the province. There is something to be said for requiring the patient to pay a portion of the cost of medicines, but the scheme has been developed on the basis of a completely free service, if the province should so decide.

Dental service cannot, in the opinion of the Advisory Committee, be provided at the outset on a complete basis. This is due to the simple fact that there are not enough dentists in Canada to go around.

Accordingly, after discussion with the Canadian Dental Association, it has been ascertained that the dental profession would be agreeable to contracting for complete free dental service to all children up to a prescribed age, say 16, and would provide travelling dental clinics to take this service into the rural parts. This will include semi-annual dental examination of all children in Canada.

In time, it is hoped that dental facilities may be expanded until the same complete service can be provided as in the case of the medical profession.

In order that preventive health services and treatment facilities may be available in rural communities as well as in the cities, it is provided in the model provincial bill that a province may be divided into administrative regions and divisions.

These regions and divisions will have to be organized with regard to population, transportation facilities, availability of hospitals and other services. Unless some such provision were made, it is conceivable that there would be a tendency on the part of doctors to gravitate towards the larger centres. A well organized regional system will provide the basis of a remunerative practice for definite numbers of medical men in each region and division, and will at the same time place medical services within reach of all.

Nevertheless, it is expected that in the early stages of the new plan the provinces may not find it practicable to provide services in remote parts of the country on the same high plane as in the large centres.

It is suggested that the system of municipal or district doctors on salary, as already developed with great success in rural Manitoba and Saskatchewan, may be the best method of assuring adequate medical care in the country districts.

Administration—

The Advisory Committee has given a great deal of consideration to the matter of administration. Here the committee encountered some conflict of opinion among the various groups consulted. For instance, organized labour is apprehensive of undue medical control resulting in what they call a "doctors' bill". On the other hand, the medical profession is unwilling to contemplate a system in which lay direction should place the medical man in an inferior position. The doctors argue with great cogency that direction and administration must be in the hands of those having professional knowledge and understanding of health problems.

The committee has sought to reconcile the various viewpoints by suggesting that the provincial administration shall be in the hands of a commission consisting of a salaried chairman, who shall be a qualified medical man, and who will be the chief executive officer of the commission.

The Provincial Health Officer or Deputy Minister of Health shall be a member ex officio of the commission, and the other members appointed by the Lieutenant-Governor in Council shall be representatives of the medical practi-

tioners, dental practitioners, pharmacists, hospitals, nurses, insured persons, workers in industry, employers, agriculturists, and such other groups as may be deemed appropriate.

The Advisory Committee would have preferred administration by the provincial health department, but the insistence of labour, agriculture and other interested groups that they should be represented on the governing body has led to the form of administration recommended. It is considered that the commission should meet not less than twice a year, and that, in practice, it will meet with considerable frequency in the early and formative stages of the plan. It might be considered advisable that so numerous a commission should form a small executive committee within itself.

Since the duties of the federal government will be confined to the administration of grants, it is considered that no corporate commission need be created.

It is recommended, therefore, that there should be a division of health insurance in the Department of Pensions and National Health to carry out the necessary inspectorial and co-ordinating functions. To overcome the difficulties of decentralization, it is proposed also that there shall be a National Council of Health Insurance, consisting of the Director of Health Insurance in the Department of Pensions and National Health, the Deputy Minister of Health from each province, the chief administrative officer of health insurance for each province, and representatives of the various professions, contributing and benefiting groups, very much as suggested for the provincial commissions.

National Fitness—

In addition to health insurance, two other proposals which have been developed very largely in the Department of Pensions and National Health will be brought to the attention of this committee.

One of them is the proposal for a national program of physical fitness for youth, which I shall now discuss.

The other is a proposed reform in the method of dealing with pensions for the blind, about which I hope to have some information for you later on.

The Advisory Committee on Health Insurance has recommended that a national health insurance scheme should provide for a series of ancillary grants to the provinces by way of financial assistance towards a half-dozen specified types of public health services.

One, as has already been mentioned, is a physical fitness program especially for young people.

Due to the fact that health insurance will require legislation by both the dominion and provincial parliaments, and the fact that the provincial legislation is exceedingly complex and will require a great deal of study, it is considered that all this proposed legislation could not be brought into operation within at least two years.

The need, however, for a program of physical fitness has been brought home to us by the war, and it is one that could be organized quickly. For this reason, it has been thought that we might consider this particular subject aside altogether from the major health scheme and, perhaps, if the committee agrees, seek to move quickly.

The proposal which has been developed in my department is for a national fitness fund and for a national council of physical fitness, consisting of a full-time director and nine members, one representing each province.

A fund of approximately \$250,000 is suggested, of which \$25,000 would be required for the organization activities of the national council. The remainder would be available for grants to the provinces as a measure of assistance for approved physical fitness program initiated and carried out under provincial auspices.

The methods which can be pursued are almost infinite in their variety. Most of the European countries have highly organized schemes of physical educa-

tion, of which one of the most outstanding is that which finds its expression in the great "Sokols" in Czechoslovakia.

Australia has had a federal fitness program for several years along the lines now proposed for adoption here. That is, there is a national fund of £500,000 out of which grants are made to the individual states. This was set up on a five-year basis.

The United States has also launched a gigantic national fitness program partly as an aid to the war effort, but with full appreciation of its permanent long-range value.

In Canada, physical education has in recent years come to be recognized as a part of the general education system, but, in spite of our national genius for sports and games, the numbers of our young people directly affected are astonishingly small. Sport, as we have it at present, seems to be aimed chiefly at the production of champions and record breakers.

Sports organized under a physical fitness program would aim at the development of large numbers of young people able to perform creditably in the popular tests of athletic prowess. Instead of one youth who can run one hundred yards in ten seconds, we would like to see thousands who can run that distance in twelve seconds. Instead of a small number of marathon swimming champions, we would like to see every young person able to swim for fifteen consecutive minutes.

An eminent authority in the United States, after commenting on the large number of young men who were *rejected* for military service said that, even of those *accepted*, only a small percentage could run half a mile at their own pace, jump over a waist-high fence, or chin themselves once.

Physical fitness is more than a mere matter of health. It is, of course, closely related to health and contributes greatly towards health, but beyond that there is the objective of physical efficiency, of ability to use and co-ordinate the functions of the body effectively.

British Columbia has for some years had a program of physical fitness under the direction of the provincial secretary's department, and known as "Pro-Rec". This program did a wonderful work among the unemployed youth in the depression period. Tens of thousands participated in organized recreational activities, including rhythmic, gymnastics, dancing and sports of all kinds.

I have seen thousands engaged in a single demonstration in the public parks of Vancouver. The sight was comparable to that of the famous Czech "Sokols". Whether this European type of physical education is entirely suited to the genius of all our peoples may be questioned, but it certainly was a success in British Columbia.

Particularly, however, we would like to encourage greater emphasis on physical education in the schools.

Another valuable field for development is in connection with our great commercial and industrial establishments.

The emphasis should, however, be laid upon giving the benefits of physical education to the greatest possible number.

Having regard to the varying interests and tastes of different groups of people, the methods pursued can be of almost infinite variety.

There are games, athletics and sports; rhythmic, gymnastics and exercises; swimming, aquatics and life-saving; camping, hiking and ski-ing—all manner of healthful vigorous outdoor activities that make a strong flexible and disciplined body.

We must also not overlook the training of instructors, teachers and leaders, for without many of these we can not hope to include large numbers of our young people.

The value of physical fitness goes far beyond mere feats of strength and agility. Whether or not it was the Duke of Wellington who said that the Battle

of Waterloo was won on the playing fields of Eton—somebody did—and, in doing so, formulated an epigram of profound significance. The old Romans had a proverb about the relationship of a sound mind to a sound body. Mental and physical alertness are closely interdependent, and the time to lay the foundation for both is in youth.

It is considered that each province will best be able to decide how to develop such a program among its own people whether by training instructors, providing premises, or subsidizing projects. The National Council, when it is satisfied that any given proposal will accomplish the desired end, may recommend to the government that an appropriation be made out of the National Fitness Fund.

Procedure—

In conclusion, a word should be said about the procedure which has been followed in bringing this proposal to the House.

In order to have this subject ready for consideration at the present session, I am free to say that I hurried the advisory committee in the latter stages of its work. The result was that, when the committee presented me with its interim report in mid-January, the report was incomplete. They gave me departmental proposals in the form of a draft bill in which are embodied their advice and recommendations with regard to the policy and structure of the proposed legislation. But, in the covering letter, the committee indicated that a further memorandum on finance and costs would be forwarded when completed.

The final report was not ready until after the first of March.

For my part, I had always considered that any health insurance bill would be referred to a committee of the House of Commons for consideration. This is, indeed, the normal practice with respect to proposed legislation of this nature which affects every citizen of the country in the most intimate and personal way.

It is obvious that, as soon as its proposals become public, many interested groups will wish to make representations, and it is always best that these representations should be presented orally and openly.

Since there would have been a committee in any event, we considered that it would meet with the approval both of the House and of the people if, in the present circumstances, we were to ask for the setting-up of a committee to deal with the broad question of health legislation. The advisory committee's draft proposals will now be placed before this select committee in their present form, together with financial estimates, which, as will be seen, are in a form permitting of a great deal of discussion and are not presented in any rigid form of finality.

There is much to be said for this democratic method of inviting the co-operation of the members of the House and of the public at large in planning a great measure of social reform affecting every citizen of Canada in a direct and personal way.

In any event, the procedure now recommended is the one which best fits the stage at which our preparations of a health insurance bill had arrived, and can be supported for its intrinsic advantages from the standpoint of producing in the shortest possible time an Act which shall be truly democratic and representative of the will of the people.

Health of Canada, 1941—

That we have need of a measure of this type is evidenced by the health records of the country.

In his report on the state of health of the people of Canada in 1941, Dr. J. J. Heagerty, Director of Public Health Services, reviewed the trends for the preceding decade. This trend may be summarized briefly as follows,—

The birth and marriage rates showed an increase.

The death rate showed a slight increase.

Infant mortality, however, declined, in the ten years, from 73 to 60 per thousand.

The maternal mortality rate was very definitely on the downwards trend, from 5 to 3.5 in the ten-year period.

Deaths from heart disease showed a marked increase.

The death rate from arterial diseases was noticeably down.

There was a slight increase in the cancer death rate.

While the decade showed a marked decrease in the death rate from diphtheria, there was an increase in the year 1941, as compared with 1940.

The influenza rate shows some extreme fluctuations, but the tendency is generally downward.

The pneumonia death rate is down, and the death rate from typhoid and paratyphoid has greatly decreased.

While the record for the decade shows a substantial reduction in the death rate from tuberculosis, the year 1941 showed an increase over the preceding year.

There is a recorded increase in the death rate from syphilis, but it is considered that this reflects rather an improvement in the accuracy of reporting causes of death than the true rate of increase in the incidence of the disease. Of course there are increases on account of the war.

Our enlistment statistics in the present war show definitely that the health of Canada is better than it was at the time of enlistment in the great war. Thus, we may say with confidence that, broadly speaking, Canada has made progress in the cause of public health, but, in many respects, the present statistical record indicates that there is room for a great deal of improvement.

Conclusion—

One hundred and fifty years ago, Europe experienced an industrial revolution. To-day the United Nations, as foreshadowed by their reconstruction programs are on the verge of a humanitarian revolution.

In the midst of the savagery and slaughter of war, we are witnessing the strange paradox of an emerging nobler appreciation of the dignity and sublimity of the human personality. Social security is recognized as an aspect of good humanity.

Social security has a three-fold character:—

- (a) It involves employment, with reasonable living standards;
- (b) Health, both preventive and curative;
- (c) Social service of many varieties.

Great strides have been made in Canada, but many serious gaps remain.

In the last century, the fight for political democracy with its reform bills, universal suffrage, responsible government and other reforms, was won.

But economic democracy still lags behind.

At Britain's side, we stand and fight in this great conflict. Let us be at Britain's side in measures of social security, with reciprocity for those of us who are there, and those of them who are here.

If we can pay for victory over the curse of Hitlerism, can we not also pay for victory over the scourge of disease, insecurity and poverty.

We must dethrone selfishness, materialism and squalor, and enthrone the golden rule in our political, economic and international relations.

"I see the people beginning their land marks—

All others give way."

SYNOPSIS OR DIGEST OF REPORT ON SOCIAL SECURITY FOR CANADA

tabled Tuesday, March 16, 1943, before the House of Commons Special Select Committee on Social Security, by Hon. Ian Mackenzie, Minister of Pensions and National Health.

The report was prepared and signed by Dr. Leonard C. Marsh, Research Adviser to the Committee on Reconstruction (former director of social research at McGill University). The report was prepared pursuant to instructions issued to the Committee on Reconstruction by Hon. Mr. Mackenzie as Chairman of the Cabinet Committee on Demobilization and Re-establishment. Dr. Marsh presented the report to Principal James, Chairman of the Committee on Reconstruction, who presented it to the government.

Synopsis and Explanatory Notes—

The report sets out:—

- (a) The main features of relevant social legislation already existing in Canada.
- (b) The methods by which these may be improved or reformed "particularly by transformation to a contributory social insurance basis."
- (c) The principles which should be considered if a comprehensive social security system is to be undertaken in the most effective manner.

PART I

THE BASIS OF THE TASK

"Provision for unemployment, both economically and socially, is the first and greatest need in a security program designed for the modern industrial economy."

"Provision for simple destitution without particular analysis as to cause may be barely justifiable when the scale of assistance is small. It is completely indefensible and of a nature to defeat efficient and constructive administration once it attains national dimensions."

"The only rational way to cope with the large and complicated problem of the insecurities of working and family life is by recognizing and registering for particular categories of risk or need."

"The basic soundness of social security is that it is underwritten by the community as a whole."

"One of the necessities for economic stability is the maintenance of the flow of purchasing power at the time when munitions and other factories are closing down and war activity in many other spheres is being liquidated . . . In this perspective, a wide and properly integrated scheme of social insurance and welfare provision of \$100,000,000 or \$500,000,000 is not to be regarded with the alarm which, with inadequate understanding, it might otherwise occasion."

"Social insurance is a direct and complete remedy for the most painful feature of assistance at low income levels because it obviates altogether the need for a means test in every specific case."

"Children's needs should be met as a special claim on the nation, not merely in periods of unemployment or on occasions of distress, but at all times. This is the basic case for children's allowances."

PART II
EMPLOYMENT

"There is a great range of enterprises, which will almost certainly only be undertaken through public initiative, which will directly remove wastes, eyesores, social costs; projects like the redevelopment of congested terminal facilities or of blighted areas in cities, the replacement of slum dwellings, the extension of rural electrification, the rehabilitation of eroded and cut-over areas in the country, which yield productive assets as well as give employment, which help to open opportunities for private investment as well as channelling public expenditure in desirable directions. The mobilization of these projects is an economic security task for the future which must be considered now."

"There is something new—or at least as yet untried—in the idea of national employment programs operating on the basis of international collaboration as a specific anti-depression measure in the period of post-war dislocation."

"It seems reasonable to assert that the employment reserve for Canada will not be safe unless it is part of at least a billion-dollar program in the first post-war year."

"There is no parallel, and nothing in common, between a public investment program designed to be part of the grand economic strategy of the post-war years, and the relief works which characterized the depression thirties."

"... the particular units which make up the total program must be justified by their economic merits and their special benefits... More systematic and most responsible protection and utilization of Canadian national resources, in forests, mines, water and soil must obviously be in the forefront of these programs."

"There should be room for leisure and culture, for projects therefore which promote the fruitful use of leisure... they should include community centres, youth hostels, demonstration nurseries, kitchens, houses and farms, research stations of all kinds as well as roads and power plants."

"The program of major works... demands, first, a co-ordinated effort of mobilization in which provinces, municipalities, utilities and private industry must be invited to join."

"Training should be brought into operation for all unskilled workers, particularly if they are still young, as soon as they show lengthy unemployment records."

"It is not necessary to emphasize further the crucial importance of turning the fullest resources of training and re-training to the problem of occupational transference immediately the need for war production is ended."

"The unemployment insurance fund at the present moment has a reserve of \$100,000,000 and to this it is adding under wartime conditions approximately \$60,000,000 a year. This is a substantial sum, but it could easily be made the basis of exaggerated optimism—It is conceivable that, at least for short periods, well over half of the insured total, and it is certainly possible that 1,000,000 may draw benefits at least for short periods."

"On the assumption that the war terminated at the end of 1943, those workers who have been in the scheme from the beginning, if they had had no periods of unemployment previously, would have rights to benefits which would maintain them for about 24 weeks." (Unemployment insurance).

"In the present (unemployment insurance) scales, the 'dependent rate' is larger than the 'single rate' by fifteen per cent. It is recommended that this difference should be increased, to raise the two-person rates to an average of nearer 50 per cent greater than the single-unit benefit."

"There are a number of compelling reasons why unemployment assistance measures additional to unemployment insurance must be considered before the end of the war . . . There will remain some hundreds of thousands of workers not covered by the scheme."

PART III

THE UNIVERSAL RISKS: SICKNESS, INVALIDITY, OLD AGE

"It should be taken as axiomatic for Canadian health insurance planning that every endeavour must be made to include the rural and farm population, and that administrative facilities must be devised to do so if they are not already existent."

"In health insurance above all it is necessary . . . to provide automatically that the contribution of the male head of the family carries with it the right to medical care for all his children."

"The government contribution (in a health insurance scheme) could be adjusted to make up the balance at each of the graduated levels. At the top it may make no contribution at all; at the lowest level . . . the state contribution to the fund would be the full amount."

"The logical requisite for the proper initiation of Canadian health insurance scheme is an income registration in appropriate form . . ."

"It should be possible to set (workmen's compensation) rates which would not be very burdensome for farmers."

"There is a strong case for a system of sickness cash benefits being organized as soon as possible in relation to a health insurance scheme."

"For gainfully employed women the proper counterpart for sickness cash benefit is maternity benefit."

"Sickness cash benefit (or temporary disability benefit), and its special complement for working women, are not only the logical supplements of unemployment insurance, but necessary for the long-run efficiency of unemployment insurance administration."

"Many of the unjustifiable restrictions as to eligibility (for old age pensions) could be removed . . . It is seriously to be questioned, for example, whether insistence on the responsibility of children for their parents is socially sound, and it is certain that, socially sound or not, insistence is impracticable."

"A maximum \$30 monthly pension, with means-testing and income-deduction more rigidly applied than at present, would be fairer to the completely destitute and dependent than the present scale of (old age pensions) assistance."

"A premium should be available, as of right, to every person reaching the prescribed age level (for old age pensions) who chooses to defer the commencement of his pension, the premium varying with each year of deferment. On the other hand, there should be provision for admission to benefit, either under

the contributory or non-contributory system of old age pensions, for persons who, before reaching the age of 65 (or 60 in the case of women), can show on competent authority that they are permanently unemployable, 'burnt out', or for some other reason unlikely ever again to return into the employment market."

"The trend is clearly in the direction of compulsory contributory insurance against retirement and old age."

"It is of first importance to realize that health insurance and unemployment insurance between them may be the two basic administrative systems for Canadian social security."

"The method of straightforward amendment recommends itself as being the most direct and unequivocal." (Amendment of the British North America Act to make possible the implementing of health insurance legislation).

PART IV

FAMILY NEEDS

"Children's allowances are a clear part of the policy of a national minimum—of the direct attack on poverty where it is bound up with the strain imposed by a large family on a small income."

"Children should have an unequivocal place in social security policy."

"It is quite possible that on account of the total costs—since there are 3,500,000 children (under 16) in Canada—the allowance might be inaugurated on a fairly low scale, provided this is not out of all proportion to the minima recognized as necessary for the support of a child. The assistance minimum... would set the average amount at \$14.50 a month, though there is evidence that at least in some rural districts lower rental costs create a small differential."

"The possibility of a contributory basis for children's allowances, in whole or part, is perhaps not to be regarded as entirely out of court under Canadian conditions..."

"Proper provision for maternity is a special matter. It will be unquestioned that the fullest arrangements for medical care should be woven into any health insurance scheme that is to be devised, and that this should be available for all women..."

"All of such plans (for assistance of widows) put together, it is fairly certain, do not go far, for the low and moderate income families of the country as a whole, towards meeting the security needs of those members who survive the death of the breadwinner... A moment's reflection on these two contrasting scales of assistance (the amount paid soldiers' dependents and that granted in mothers' allowances) will suffice to mark the inadequacies of present provincial mothers' allowance legislation, and the need for a post-war adjustment of the situation."

"The remaining problem for the future will be to provide an income on the basis of security maintenance to enable the widow to maintain herself while looking after her family."

"There can be little question that if it were possible to include a moderate funeral benefit in a social insurance scheme... it would be a decided contribution."

"The British social security budget represents about \$3,200,000,000...an equivalent sum for Canada would be \$800,000,000 to \$900,000,000."

"If social security for Canada involves something approaching a billion dollar program, it must be remembered that not all of this amount of collection and disbursement would be tax-financed or state funds; and it must be measured also against the wholly new levels of national production and Dominion budgeting that a war economy has brought into existence."

ASSISTANCE MINIMUM STANDARDS

In establishing assistance minimum standards, Dr. Marsh made use of a study conducted by the Welfare Council of Toronto in 1939 to cover the items necessary to ensure health, reasonable living conditions and general self-esteem for a family, and the cost thereof. Comparison was also made with similar studies and standards in other countries.

The purpose of the budget was to establish the line at which there would be certainty over a long period for better than subsistence standards for a family of five. Valued for 1939, this would require \$28.35 a week, or \$122.85 a month.

Dr. Marsh continued:—

"A careful assessment of the Toronto Welfare Council budget has been made, and the reductions possible on a subsistence basis result in figures of \$10.30 weekly for two adults and \$3.40 as an average for each child. These would be monthly amounts of \$44.50 and say \$14.50, respectively."

"The restrictions this embodied include more crowded housing accommodation and the absence of any allowance for advancement expenditures or savings at all, on the grounds that there is least room for safe economy on food."

"The lower standard must be regarded as conceded rather than recommended; a level which it is desirable to raise. In social insurance terms, if it is used to set benefit rates, the assumption or the hope would really be that supplementary sources of income might be available."

"The benefit rates would be a nucleus, perhaps an encouragement, for personal or industrial provision, through annuities, superannuation, and the like. It follows, of course, that application of means tests would be quite inappropriate."

The report gives a table showing that the desirable living minimum for a family of five (three children) in 1940-41 would require an annual income of \$1,577.40 or \$131.45 a month, while the assistance minimum would provide \$1,134 annually or \$94.54 a month.

The desirable living minimum for a man and wife in 1939 was set at \$69.29 a month, with the assistance minimum \$44.46.

The assistance minimum budget indicated above would require an annual income of \$1,134. For the year 1940-41, if \$1,000 earned by the head of the family was assumed to be equivalent to this amount, 33.4 per cent of urban families were below the assistance minimum, and in rural districts, at a conservative estimate, the figure was more than 50 per cent.

The CHAIRMAN: Thank you, Mr. Minister, for your very comprehensive and interesting report and for your physical effort in presenting it. Mrs. Casselman, and gentlemen, while the bill is being distributed may I ask your advice? I have here the report on Social Security for Canada presented by the Advisory Committee on Reconstruction. This comes to our committee as well as to the Reconstruction Committee. It is very voluminous.

Mr. WOOD: It is generally known as the James Report?

Hon. Mr. MACKENZIE: The Marsh Report.

Mr. WOOD: Oh, yes.

The CHAIRMAN: It was prepared by Dr. Marsh with the assistance of Dr. Bevis and Dr. Peebles, and so on. It is a very extensive document of about

160,000 words. I think it should be printed. What is your wish regarding it? How many copies do you wish? Various numbers have been suggested to me from 1,000 to 10,000. I should like to get your suggestions with regard to this.

Mr. LOCKHART: Is the report of such a nature that it would be liable to be requested by all types of organizations?

The CHAIRMAN: Yes, I think it is, undoubtedly.

Mr. LOCKHART: We ought to have a sufficient number to meet the demand.

The CHAIRMAN: Have you a suggestion?

Mr. LOCKHART: I would rather leave it to those who have read the report. I would hesitate to venture.

The CHAIRMAN: Is the committee willing to leave it to the chairman and the minister?

Some Hon. MEMBERS: Yes.

The CHAIRMAN: Agreed. Here are two other reports.

Hon. Mr. MACKENZIE: Everything on health in the world is there.

The CHAIRMAN: This is the so-called Heagerty report. It is a very interesting and extensive report. These two should be printed.

Hon. Mr. MACKENZIE: I think they are very valuable documents. They are full of very profound factual information. There are no conclusions reached, but as the committee will be studying these things for some time to come I think they will find it invaluable. You will also have requests from outside from all kinds of public organizations.

Mr. McCANN: How many copies of the Sirois report were there?

Hon. Mr. MACKENZIE: The idea that we had was that it would be printed just along the lines of the Sirois report.

Mr. McCANN: It is equally important, and I think probably we might be guided in the number of copies that should be printed and distributed by the number that were printed and distributed of the Sirois report. I was going to suggest that although it has been left to the minister and the chairman to decide with reference to the printing of the Marsh report, probably this committee ought to request that the same number be printed as is printed of the proceedings so that there can be early distribution to the members of the committee, members of the House, and those who are immediately interested; and that the matter of a further printing for the public be left to the government.

The CHAIRMAN: That is, Dr. McCann, that the initial printing should be at least the same number as the proceedings.

Mr. McCANN: Exactly, 1,500 and 700; and that the matter of further printing for the public be left to the government, because they will be guided by the number that will be required, say, of the Sirois report and the Heagerty report too. I think that ought to be done. That will take a comparatively long time and ought to be done as soon as possible so that those who are interested may have the reports with a view to studying them.

Hon Mr. MACKENZIE: We have sufficient copies here for the members of the committee to be distributed immediately.

Mr. SLAGHT: Those deciding the number will not overlook the fact that the provinces will require a goodly number of copies, medical associations in each province will also require a goodly number of copies, and it would not be fair not to give them to them.

The CHAIRMAN: That will be met.

Mr. KINLEY: How will distribution be made? For instance, members here will send out a certain number to the provinces; the provincial government will send out some to associations in the provinces; and will there not be a duplication there? Voluminous printing and duplication should be guarded against.

The CHAIRMAN: I think we can handle that through the applications that come in for copies. That will have to be safeguarded against.

Mrs. CASSELMAN: The Sirois report was sold to some extent.

The CHAIRMAN: Yes, it was and the Beveridge report is being sold. It is not your intention that these reports be sold, Mr. Minister? Has the committee any comment to make on Dr. McCann's suggestion?

Mr. WRIGHT: I think probably these reports should be printed by the government and sold at cost. I think the Beveridge report has been handled in that way.

The CHAIRMAN: That will be considered.

Hon. Mr. MACKENZIE: If the committee recommends it, it might help us to get it done.

Mr. WRIGHT: I would suggest that.

The CHAIRMAN: Will you move that?

Mr. WRIGHT: Yes, I would move that the government have these reports printed and sold at a reasonable cost.

Mr. LALONDE: Sold at a certain price to anyone who wants the report, outside of the members of the house.

The CHAIRMAN: I should like to get Mr. Wright's motion clear. I understand, Mr. Wright, you ask that copies of these reports be sold at a reasonable price exclusive of the copies given to the members of the committee and the members of the house.

Mr. WRIGHT: Yes.

The CHAIRMAN: And the provincial government?

Mr. WRIGHT: Exclusive of the 1,500 that would be printed. I am now speaking of the amount over and above the 1,500 that are going to be printed and distributed to the members of the committee and the members of the Senate and others. It is up to the committee to decide whether they want to have the 1,500 sold, but I am more particularly referring to the number distributed over and above the 1,500 that are to go out to the members of the house and the Senate.

Mr. LALONDE: I would not say that. I understand that it will cost a great deal of money to print these reports. We have decided on the numbers that are to be printed and distributed to the members of the house and the Senate and the other persons interested, but there may be some other persons outside of the house who are also interested. I would not confine distribution to the members of the house, members of the committee and to the Senate.

The CHAIRMAN: You are now referring to free distribution.

Mr. LALONDE: It is up to the members to decide whether they should distribute only to the members of the house and to the Senate. Owing to the large cost involved in printing government reports I think free distribution should be limited. I understand 1,500 copies in English and 700 copies in French are too many free copies to be distributed outside the house.

Mr. KINLEY: There are 245 members and 96 senators.

The CHAIRMAN: Dr. McCann, have you a word to say?

Mr. McCANN: As I understand it, these reports are not reports made to this committee, they are reports made to the government or to the Department of Pensions and National Health and through the minister this morning they have been put on the table and read into the record. I submit that all we have to do is to decide the number that we will require for the committee and for parliament. The rest of the distribution is entirely up to the government or up to the department, based upon the demand, and if the department or government see fit to make a charge for the distribution of those copies, which I think

they should, it is a matter entirely up to them. Let us concern ourselves with what has to do with the committee, that is, the immediate distribution of copies to the committee and to the members of the house and the Senate and those associated with the different bodies immediately concerned.

Mr. LOCKHART: These things have now become public property, at least in a sense. There will be a demand immediately created. How can this committee establish just what that demand will be? There is nobody better qualified than the minister and his associates to act on the demand that develops for these reports. I cannot see any sense in wasting our time on this discussion this morning.

Mr. WRIGHT: My suggestion was this: I thought the 1,500 would be distributed freely to the members of the house and to the Senate and the various legislatures that would be dealing with the subject. Outside of that I think the copies should be sold.

The CHAIRMAN: We will proceed with Dr. McCann's suggestion and we will report back to the committee with regard to the sale. Is it your wish that we should meet on Friday? The Reconstruction Committee meets on Wednesday and Thursday. We should meet on Friday and decide on definite dates each week after consultation with the other committees. Shall we meet on Friday at 11 o'clock?

Mr. McCANN: What is the proposal, or has the committee a proposal to make with reference to the agenda of business? I would suggest that it would probably expedite business if the chairman would pick a small steering committee and let them make a proposal with reference to the agenda.

The CHAIRMAN: That will be done.

Mr. McCANN: Let us attempt to have such a program that in some well executed orderly manner we will consider extensively the public matters which will present themselves to the committee. Let us decide early as to whom we shall call before the committee. I would suggest that we have some type of orderly sequence to the whole matter. I think if we do that we will make a good deal of progress with our work.

The CHAIRMAN: That will be presented to you on Friday for your consideration.

Mr. MACINNIS: On that point, Mr. Chairman, I agree with what Dr. McCann has said. The work of this committee should be based largely on whether we are going to do work that will go over more than one session, or whether we are going to do work that can be put into legislation at this session. If we are going to do work that is to be embodied in legislation at this session we will have to confine ourselves to a small part of what has been placed before us to-day. I think we should be very clear on that, because there are certain things that could be done now, and there are certain things that could not be done now, that will have to go over a long period of time.

Hon. Mr. MACKENZIE: That is right.

The CHAIRMAN: That is correct. We will discuss the question of agenda on Friday when we will also hear from Dr. Heagerty and Mr. Watson if there is time.

The Committee adjourned to meet again Friday, March 19, 1943, at 11 o'clock, a.m.

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Committee on Social Security, 1943

SESSION 1943

HOUSE OF COMMONS

CAI XC 2

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

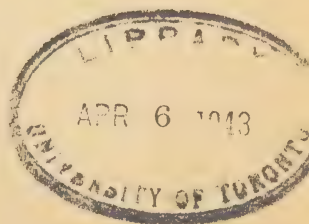
No. 2

FRIDAY, MARCH 19, 1943

WITNESSES:

Mr. A. D. Watson, Chief Actuary, Department of Insurance, Ottawa.
Dr. J. J. Heagerty, Director of Public Health Services, Department of
Pensions and National Health, Ottawa.

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1943



MINUTES OF PROCEEDINGS

FRIDAY, March 19, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Bruce, Casselman, Mrs. (*Edmonton East*), Cleaver, Diefenbaker, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Hatfield, Lalonde, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGregor, McIlraith, Maybank, Mayhew, Picard, Shaw, Veniot, Warren, Wood and Wright.—28.

The Chairman asked the Committee to approve of the following members as a Subcommittee on Agenda: Messrs. Macmillan (*Chairman*), Blanchette (*Vice-Chairman*), Diefenbaker, Gershaw and MacInnis.

Approval was given.

Mr. Diefenbaker moved—

That the Department of Justice and the Department of Pensions and National Health produce all letters written by the Federal Government to the Provincial Governments respecting co-operation in the adoption of Health Insurance Measures. Motion agreed to.

Mr. A. D. Watson, Chief Actuary, Department of Insurance, was called. He tabled a memorandum respecting the objects of a "Draft Health Insurance Bill" which is printed as Appendix A to this day's evidence. Copies of same were distributed to members of the Committee.

Dr. J. J. Heagerty, Public Health Service Director, Department of Pensions and National Health, was called and examined. He tabled a memorandum and Draft Bill respecting "Physical Fitness." Copies were distributed to members of the Committee.

The witness retired.

The Committee adjourned at 12.50 p.m., to meet again on Tuesday, March 23, at 11 a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS, March 19, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m., the Chairman, Hon. Cyrus Macmillan, presiding.

The CHAIRMAN: We shall proceed to discuss the problems involved by progressive steps, discussing and I hope concluding discussion on each topic before commencing the next one. We shall first discuss health insurance and then physical fitness.

This morning we have Mr. A. D. Watson, Chief Government Actuary of the Department of Insurance, who wishes to present a statement that you might consider over the week-end and discuss later.

Mr. Watson, will you come forward?

Mr. DIEFENBAKER: Will you permit a motion at this stage, Mr. Chairman?

The CHAIRMAN: Yes.

Mr. DIEFENBAKER: It is this: in order to study the whole situation relative to health insurance, in view of the divided jurisdiction between the dominion and provincial governments, I think that we should be in a position now to give some attention to the question as to what powers the dominion parliament will have to pass health insurance legislation. I would therefore move that the Department of Justice or the Department of Pensions and National Health be requested to produce copies of all communications, letters, and so on, that have been written by and on behalf of the federal government to each of the provincial governments, which have been designed to secure or in connection with the securing of the co-operation of the provinces in the passing of health insurance by parliament.

I think if we have that at the earliest possible opportunity it would be most helpful, and I so move.

Hon. Mr. MACKENZIE: There is no objection whatsoever to the motion. As far as my recollection goes there was no direct correspondence specifically related to health insurance, but we did have a meeting with the provincial ministers of health. Of course, they were not able to bind their government. Personally, I would welcome very much the opportunity of producing anything we have. We have had oral discussions with the Minister of Justice on that question, and I should be glad to give the committee later on our views in that regard. I would personally welcome it if the provinces would give their views here or anywhere else.

Mr. MAYBANK: Can you give us what Mr. Diefenbaker has asked for by way of a statement, and that might cover the point and cover it much more quickly?

Mr. DIEFENBAKER: If we had the communications we could peruse them.

Hon. Mr. MACKENZIE: If there are any they certainly will be produced; I do not know of any.

Mr. MACINNIS: I have no objection to Mr. Diefenbaker's proposal and possibly it might be helpful, but I do not think that it would be helpful to us in dealing with the constitutional question. It seems to me that would be dealt with when we know what changes are required after we know what this parliament is going to ask for and if and when a constitutional question really develops. I have no objection to the other matter, but it won't just meet what he is asking for.

The CHAIRMAN: Mr. Diefenbaker's motion is therefore approved, is it?

Motion agreed to.

Mr. A. D. WATSON, called:

The WITNESS: Mr. Chairman and members of the Social Security committee, I am depositing a memorandum explanatory of the proposed draft for a health insurance bill. In this memorandum is given in summary form the considerations and reasoning which led to the conclusions embodied in the terms of the proposed draft, together with a summary of the main terms.

(Memorandum appears as Appendix "A".)

By the Chairman:

Q. I understand that at a later stage of the committee you will present a statement?—A. Yes; I want to prepare a statement, yes.

The CHAIRMAN: Mr. Watson has tabled this document, which is explanatory of the proposed draft bill on health insurance which is now in your hands, and later Mr. Watson will return to answer questions that may be asked and also to present a supplementary statement.

By Mr. Maybank:

Q. May I just ask Mr. Watson this question? I gather this memorandum is to tell us the cost of the bill; is that right?—A. No, the terms of the bill.

Q. So that although Mr. Watson is an actuary this statement does not go into that part of it. Well, Mr. Chairman, may I ask this: Doubtless the cost feature will be gone into at some stage and I wanted to make sure that the various offsets would be before us. For example, we are giving certain medical aid; we give certain health insurance, and things like that. Certain municipalities are doing something of that sort now. I should like to know if the amount, if we can get it, of each would be set off in various parts of Canada. I have no doubt the steering committee have that in mind.

Hon. Mr. MACKENZIE: That is all being worked out.

Mr. MAYBANK: You would have to have some on the left as well as on the right.

Hon. Mr. MACKENZIE: We have.

Mr. MAYBANK: You have?

Hon. Mr. MACKENZIE: Yes.

The CHAIRMAN: Dr. Heagerty will now make a statement.

Dr. J. J. HEAGERTY, called:

The WITNESS: Dr. Macmillan has suggested I give you my name and position. I am Dr. J. J. Heagerty, Director of Public Health Services of the Department of Pensions and National Health.

The CHAIRMAN: Will you proceed in your own way?

The WITNESS: I have not prepared a speech; I am not going to bother you with one, you hear enough speeches during the course of the year. I stand up only because I am rather short and I find it easier to reach your height by standing. I have not prepared a formal presentation. I thought I would rather run over in my own mind certain facts with which I am familiar in connection with health insurance and by doing so give you a picture of the whole thing.

Our ideas with regard to health insurance have undergone a change, as you know, since the German system was introduced in 1883. In that year Bismarck saw the rising of socialism and felt he had to do something about it, either to swing in or oppose it, so he tied in with the movement by forcing wage-earners to insure themselves in certain existing societies and compelled employers of labour to contribute. In that way he pleased the workmen and pleased the socialists. Later on other countries followed along the same line and in 1911

Lloyd George introduced health insurance into England. It is said that he sold health insurance on the basis of giving the workman nine pence for four pence.

Now, at that time all that he gave the wage-earner—it was only the wage-earners who were cared for under health insurance in all European systems up to that time—was the visit of the doctor and the drugs and a cash benefit.

The idea was very largely economical; it was politico-economical from the start.

It has been demonstrated that there has been no improvement in the health of the British people through health insurance since it was introduced in England, put into effect in the year 1912.

In the first year 60 per cent of the insured people called for the doctor and 60 per cent of the people still call for the doctor. Later on it became obvious that medical care alone was not the best method of handling the problem of health as far as it affected the people of the various countries of Europe, and some of them began to give consideration not only to the working man but to his dependents. In 1920 Sir Arthur Newsome came out to the United States and under the auspices of the Millbank fund he enunciated the idea that public health preventive medicine should play a primary part in health insurance and he used the words "positive health" which are bandied about now for the first time. He had the right idea; and countries since that time which have adopted health insurance have endeavoured to integrate preventive medicine with medical care. There is not any point in introducing a medical care system unless it is integrated with preventive medicine. There is no use going on paying out sums of money year after year for the treatment of diseases that are controllable by public health measures. One of the most recent public health plans that has been adopted has been that of Chile. Chile has adopted really different ideas from those that were in existence in Europe. Chile said to itself, "We must do something for the health of the people of this country, not merely provide them with doctors and nurses and hospitals." Chile started out by conducting a medical examination of all of its people. Since health insurance has been introduced into Chile—and it is not complete as yet, they are still working on it—250,000 people have been given blood tests and have been X-rayed for tuberculosis; and all of those who have been found to be suffering from syphilis and tuberculosis have been put under medical treatment free.

That gives you an idea of the modern trend and it is something of that nature that we have in mind in Canada in preparing and planning health insurance; although we have not gone as far or gone to the extent that Chile has gone, nevertheless Chile is moving in the right direction. In order to carry out their plans they are gradually dividing the whole country up into group clinics, little Mayo clinics, if you like.

Now the planning commission of the British Medical Association has in its first and interim report recommended that the whole of Britain be divided up into group clinics. They point out that it will not be possible to establish those group clinics in rural areas to the same extent as in urban areas, but it is their suggestion that the modern approach to this whole problem of the prevention and the treatment of disease—it is their idea that public health should be linked up with preventive medicine. As you know, Sir William Beveridge recently has suggested that the entire administration of health insurance should be under the Department of Health. In making that statement he has supported the view that was expressed by the Royal Commission on Health Insurance in England in 1926. That, of course, is just one man's view. However, if you will read his proposals in connection with health insurance you will find that he has suggested that the British Exchequer contribute some three-quarters of the entire cost of public health and medical care. He sets the cost at 170 million pounds, of which he proposes that the British Exchequer should contribute 130 million pounds.

I do not think it is necessary for me at this time to go into a detailed discussion of the various health insurance plans that are in existence throughout the world, because you will find a summary of each and every plan contained in the first volume of the report that has been made to you and which has been referred to as the Heagerty report.

Now, members of the committee, this is not my report; this is the report of the Advisory Committee on Health Insurance. When I selected the members of my committee I confined myself to government officials because I felt that they had a very distinct contribution to make. I selected them for the information that they had to give and I think if you will permit me to run down the names of the members of the committee you will see that each one has engaged in some particular line of endeavour that was helpful to us in formulating our plans.

Any plan of health insurance must be based upon statistical, sound statistical information. It must cover everything in the way of statistics that the country has to present. You will find in the second volume that the statistics cover population, for example. You cannot begin to attempt health insurance until you know your population. You have got to know the trend of your population. You have got to know what it is. You have got to know it from the dominion standpoint. You have got to know it from the provincial standpoint. You have got to know whether the progress is from east to west, or from west to east; and you have got to know the various factors that influence population. So we have given you a very large section along that line.

You must also have vital statistics. You must know your problem, and you cannot know your problem unless you know the diseases with which you have to deal.

Again, you must know all angles of the subject. You must know the financial status of the country and of the provinces as well. So that we have a section compiled by the Bureau of Statistics to deal with the question of incomes. But I will not go into that any further; because, when you read the report after it is printed you will find that there is a great deal of information that has been provided. But, may I run over the names of the committee.

There is Mr. A. D. Watson, Chief Actuary of the Department of Insurance. Now, Mr. Watson, as his title and name would indicate, has made a very valuable and important contribution both from the standpoint of the actuary and from his knowledge of previous insurance measures in which he participated, such as unemployment insurance. He was invaluable to us in drawing up the various sections of the plan.

Mr. A. S. Cudmore is the Dominion Statistician, and you all know him.

Mr. J. T. Marshall, Chief of the Vital Statistics Branch of the Bureau of Statistics deals with mortality in its relation to the population, and other factors.

Mr. J. C. Brady, Chief of the Institutional Statistics section of the Bureau of Statistics, was able to give us anything and everything about hospitals. We have a very large section that deals with hospitals; and in addition to that we have a section prepared by Mr. Marshall that would tell you from the year 1926 on every day lost through illness by workers in every city, in every town, in every village, and in every hamlet in Canada. There is a huge section that deals with that alone, because that is a very important piece of knowledge that we must have.

Now, Mr. S. B. Smith, Chief of the Business Statistics division of the Bureau of Statistics, deals with business statistics; it is obvious that we must know how this is going to affect business.

Miss M. E. K. Roughsedge, of the Employment Statistics division of the Bureau of Statistics, deals with employment statistics, and she gave us all the information, very necessary and valuable, regarding employment in Canada;

employment with respect to wage-earners, agricultural workers, fishermen and others; because we felt that if this plan was ever put into effect it should cover the entire country and all classes of people.

Mr. J. R. Munro, Chief, Financial Statistics division of the Bureau of Statistics, has prepared a very large section in the report for us.

Then, Mr. L. C. Marsh, Research Adviser on the Committee on Reconstruction—unfortunately he could give us only a small part of his time. He attended only three or four meetings and was very helpful to us.

Then, we have Mr. W. G. Gunn, Departmental Solicitor of the Department of Pensions and National Health; he was extremely helpful in giving us legal advice and information in regard to the various sections we drew up.

Then, finally, Mr. C. E. Stevens, Employees' Compensation Branch of the Department of Transport, dealt with workmen's compensation.

Now, let me go back to three years ago next May when Mr. Mackenzie thought something should be done about the health of people of Canada. He approached his deputy minister and suggested to him that at the next meeting of the Dominion Council of Health which was to take place in June, and which comprised representative members of the medical profession, all voluntary health organizations should be invited to attend; and that the whole subject of public health and medical care should be discussed, and that they be asked to formulate a plan of health insurance.

It has now been my lot to present the subject of public health and medical care at that meeting. Now, for your information, the Dominion Council of Health is the linking-up body, the body which links up the dominion with the provincial departments of health. It comprises the chief medical officer of each of the provinces and representatives of women's rural organizations, women's urban organizations, of labour, of agriculture and one expert adviser, with the Deputy Minister of Pensions and National Health as chairman.

I decided at that meeting that perhaps the best thing I could do would be to confine my discussion to the field of public health. You will find that laid down in this plan. And I think it would be as well, if you will permit me to do so, briefly to recall that in order that you may get a complete picture of the health of the people of Canada; rather the deficiencies in the field of public health in Canada; and in that way know why we have decided to do something in regard to public health.

One of the first subjects that we dealt with was maternal mortality. We thought that was extremely important; but it was only when we made a study of population that we really realized how important that was. I do not know whether I can find it here at the present moment, Mr. Chairman, but if not I will just make a statement in regard to it. However, we have found that from the standpoint of population we are not making progress in Canada. There is falling birth rate. We have no immigration. The young people are leaving the country in fairly large numbers; and we note instead of the progressive increase that we had over a very large period of years that we have now what is becoming a decrease. Whereas the increase was relatively twenty per cent from the year 1911 down to 1921, it is now down to ten per cent.

Now, mortality: maternal mortality is an extremely important factor in respect to population. And, now, what is the situation in respect to maternal mortality in Canada? We have been losing an average of a thousand mothers each year. It is down a little during the last two or three years due to the concentrated efforts of the provincial departments of health. When a mother dies, the child usually dies. The child dies because there is no one to care for the child. We would like to have incubators—to take the newborn child to the hospital—we haven't got them and we cannot get them, we have no money for them. Why have we this condition? We have been losing over the past ten years on an average of 15,000 children under one year of age each year. The

figures dropped in 1940 to 13,000 odd, but since the war it has gone up; so we are losing these thousand mothers and 15,000 children under one year of age. And, in addition to that, we are losing 16,000 people a year through communicable diseases. Now, maternal mortality is terrible; infant mortality is terrible; but let us look at infant mortality in passing from the one-year-old child to older children. Would you tell me why a child should die of measles? Is there any reason for it? The answer is, the only reason is poverty on the part of the parents who just cannot afford to call a doctor or a nurse; or call them only when it is too late.

Why should a child die with whooping cough? Why should a child die from scarlet fever? We lose more children with measles than we do with scarlet fever because the state takes hold of everything in the case of scarlet fever, pays for hospitalization and medical care. Many adults were lost—a very great number from influenza, pneumonia and other conditions.

But there are two physical conditions that should give us a very great deal of concern; one of these is tuberculosis and the other is mental illnesses. Tuberculosis jumped up in 1941 on account of a great many young people going into industry without proper housing conditions, under-nourished, pushed around; many of them have developed tuberculosis—it may have been pre-existent before they went into industry. Why hasn't something been done about it? They have not been X-rayed, they should be X-rayed. Since the war tuberculosis has stepped up from eighth place to seventh place as a cause of death. We have an increase in the number of deaths attributable to tuberculosis directly on account of the war.

And now, what is the situation in regard to tuberculosis in the various provinces of Canada? Can you do anything about tuberculosis? Well, you take Quebec and Ontario. They are very, very close together. They have the same air, very much the same living conditions; and you find that the death rate in Ontario is twenty-five, as compared with eighty in Quebec. Why is that? Ontario has provided practically free treatment, it is now X-raying all the people of the province at a cost of 30 cents per X-ray. In Saskatchewan the death rate is twenty-nine. Free treatment is provided in Saskatchewan. There are two provinces in Canada which have adequate facilities for the prevention and treatment of tuberculosis; these are Saskatchewan and Ontario.

The death rate in New Brunswick is very high. There is a peculiar situation associated with tuberculosis in certain areas in Quebec and New Brunswick. In certain districts in Quebec where the death rate from tuberculosis is extremely high—and in New Brunswick it is the same—we find that blindness is excessive. Now, we did not consider for a long time that blindness had anything to do with it in relation to poverty, but now we find that in these areas where tuberculosis is greatest and where blindness is greatest that poverty is also the highest. Now, it is noted that malnutrition and bad housing are factors having to do with both of these conditions. And now, it is obvious that Ontario and Saskatchewan have succeeded in reducing the tuberculosis death rate and that it could be done in the other provinces; and we know that given an opportunity we can eliminate tuberculosis altogether in one generation; and it does not take very much money to do it. We are proposing in this plan that we should make a grant to the provinces for the prevention of tuberculosis and for the extension of their public health services.

But, let us take insanity; or, mental illness as it is called to-day. The situation in regard to mental illness in Canada is to-day grave; and I use that word "grave" after due consideration. There are in our mental institutions here in Canada at the present time some 47,000—I am dealing in round numbers—persons. There are not that many beds. We are short about 10,000 beds. Now, when you place persons who are mentally ill in institutions higgeldy-piggeldy you cannot separate them or segregate them according to their particular

forms of mental illness. There are not enough doctors. There are not enough nurses, not enough well trained nurses, and there are not enough orderlies. We have not given any real thought to the situation of mental illnesses, and it is staring us in the face; because when these people go into an institution, a very large number of them stay there, and one result of that is the numbers increase all the time. Now, we are told by the experts—and they tell us the truth—that a great deal of mental illness is preventable. There are psychiatric clinics; some of the provinces have established psychiatric clinics while others have not; some have done very well in that field—but these men tell us that if they can get hold of children who have either the hereditary factor or an inclination towards mental illness that they can do a very great deal with them. Now, our institutions are filled, and on the other hand there are many people in these institutions who are capable of working under supervision provided they have no mental stress or strain at work.

Now, we propose to make a grant for the free treatment of those who are insane. Why free treatment for tuberculosis? Why free treatment for those who are mentally ill? If you check up the figures you will find that over ninety per cent of the people, the wage-earners of Canada, have an income of \$2,400 or less, two-thirds of the married men of Canada with families have \$1,200 a year or less. Now, it costs you quite a little bit of money to hospitalize a person for either tuberculosis or insanity.

Now, there are two important conditions that stare us in the face and can be solved only by improving the public health situation, by providing medical care. I asked a little while ago, why do these children die? Because they haven't a doctor, or because they haven't nursing care. These children who are going to grow up as mental defectives have not had a doctor and have not had nursing care and have not had the necessary supervision. Children are particularly susceptible to tuberculosis. I do not think it is in any way exaggerated. There is no doubt that given the opportunity we can control this condition and do it very well.

What is the situation in regard to venereal disease in Canada? As you know, the venereal disease problem has at all times been an extremely important one. When we first lectured on the problem of venereal disease we perhaps had a tendency to exaggerate.

In 1920 the dominion government voted the sum of \$200,000 for the control of venereal diseases. All of the provinces established free treatment in clinics and passed legislation both for reporting and compulsory treatment. In the year 1932, when the grant was discontinued, we had cut syphilis in two. We had materially reduced gonorrhea. Since 1932 syphilis has been stationary in Canada. Since the war, of course, there has been an increase. There has been an increase in gonorrhea. With modern treatment—and treatment has improved to a very great extent—and with the integration of public health measures, we can bring venereal diseases under control to as great an extent as in Sweden, where they have been dealing with the subject for 130 or more years. There are about seven new cases of syphilis per 100,000 of population in Sweden a year. Our figures we do not quote, because it is only the clinics which report to us. The doctors do not report their cases. We figure, according to clinic figures only, that there are seventy new cases per 100,000 population per year, but we know the figure is very much higher than that. In respect to gonorrhea we have no idea whatsoever of the number of cases. Fortunately, with the sulpha drugs, the complications that we used to see are no longer found.

I hope I am not taking up too much time on this, Mr. Chairman.

The CHAIRMAN: No. Go ahead and take all the time you wish.

The WITNESS: Having discussed that subject, and others that you will find outlined in these memoranda, we come to one in particular, physical fitness. You know the situation in regard to physical fitness. It is not necessary for

me to repeat it or to discuss it. The army figures have been brought forward; but we are loath—those of us who are in the public health field—to accept army figures, because the army wishes perfect individuals. We prefer to take the general population. Just a very few years ago—in 1938, I believe—a study was made of over 3,000 children in Manitoba. Seventy per cent of them were found to be suffering from physical defects. Do not be misled by that. The majority were suffering from minor physical defects, but still some of them had tuberculosis, some of them had hereditary syphilis, and some of them had serious conditions that needed to be cared for but they were not being cared for. So we put an amount in the health insurance bill for physical fitness. We put it in there pending the formulation of a physical fitness bill. We thought, and still think, that physical fitness should be treated as a separate and distinct entity—that is, from the standpoint of the mental, moral and physical development of the young—along the lines that were introduced in Europe some time ago, approved in Great Britain and recommended by the League of Nations. You will find that laid out in the memorandum which I have given you and also in the bill.

Let us proceed from that discussion. At that meeting, after having outlined all of these facts, the Dominion Council of Health passed a resolution recommending health insurance and grants for these particular public health purposes. Mr. Mackenzie instructed us to go ahead. He gave us the green light to continue our studies into public health and medical care, and to formulate a plan of health insurance. We have the plan ready. Our first step was to avoid the mistakes and misunderstandings that were made in other countries. In other countries health insurance acts have been passed over the heads of the medical profession, the dental profession, the nursing profession, and hospital groups, with the result that there has been and still is, in some of the newer countries, dissatisfaction in regard to the operation of the scheme that was put in by parliament without consulting these professions.

The first step, of course, was taken by Mr. Mackenzie when he created the advisory council on health insurance. The next step was taken by him when he invited the medical profession to appoint a committee on health insurance to sit in with the advisory committee and to discuss all phases of the problem. So far as I know, that is the first time that a medical association has sat down with a group of individuals who were planning health insurance. We had very many meetings and many discussions. I myself drew up three plans of health insurance and submitted them to Mr. Mackenzie, and also to the Justice Department, and finally to the medical profession. The medical profession was co-operative. It took—and I think Dr. Routley will agree with me—some considerable time before we saw things with the same eyes, but we did succeed in obtaining the full co-operation of the medical profession. We then called in the dentists, because we felt that without dentistry our plan would not be as successful as it should be. I was not at the time considering only the children who were suffering from decayed teeth—and about 95 per cent of them have decayed teeth in certain areas of cities. That is found in New York in public schools. It has been found in certain areas in Canada. But I was thinking of the damage that is done to the older individual by infected teeth, by abscessed teeth—angina pectoris, kidney conditions, heart conditions, diabetes—all of which are caused by some damaging substance, either a germ or a toxin. So we approached the dental profession and we said to them, "What can you do to help in this plan?" They said, "We are very happy to co-operate with you to the fullest, but we feel that all we can do at the present time is to provide the children of Canada, possibly up to the age of sixteen, with a semi-annual examination of the teeth, and such remedial dentistry as is necessary." They said, "If we had all the money in the world, we could not provide full and complete dentistry for everybody," because they would not have enough

dentists; and of course, as you can quite understand, it would be a difficult thing to draw up a dental plan that would provide everybody with everything that he or she wanted in the field of dentistry.

Our next approach was to the nurses. The nurses came to us and co-operated with us to the fullest. They set forth their ideas. They were willing to co-operate, to give every service that they possibly could, but they would like to keep the nurses themselves, to keep them under their own jurisdiction. Then the hospital people came along and they also indicated their willingness to co-operate. Each of them formed committees.

The next step was to consider—and I think we should discuss this openly—the question of the relation of the great Catholic hospitals and religious orders throughout the country. They have a particular stake in health insurance, inasmuch as all of their hospitals are privately owned, and they fear national socialization. They fear communism. They fear undue and unnecessary interference with their hospitals. The Catholic Hospital Association of America, on which are representatives both of the United States nursing field and the Canadian nursing field, at their meeting in Antigonish in September, 1941, passed a resolution calling the attention of the Catholic hierarchy to the very grave danger that threatened Catholic hospitals throughout Canada. Since that time a Catholic study group, I am informed, has been formed extending from coast to coast, that is responsible to three bishops—Bishop McNally of Halifax, Bishop Vachon of Ottawa and Bishop Carroll of Calgary. So you have to consider all of these interests.

When we came to consider the question as to whether we should put in a great national scheme or whether we should deal with the problem along provincial lines, we had to give consideration to the various rights that were impinged upon by any national scheme of health insurance that might be introduced. We had the advice of Mr. Gunn, our solicitor, who is familiar with these things, and he pointed out that health insurance cut right across all provincial rights. First of all, let us take education. Assuming that the dominion were to adopt health insurance and administer it nationally, it would necessarily want certain educational rights handed over. It would want the right of setting up standards of education for admission to study medicine, standards governing the study of medicine. It would want the right to register and to license graduates of universities. We are endeavouring to integrate public health with health insurance, and it would be necessary for the dominion to take over the public health bodies of the provinces. Then there is the question of property rights. As I pointed out, these Catholic institutions do not want their hospitals to be taken over by the dominion or by any particular group. Then there are civil rights that enter into this question, such as the right of the individual to choose his own doctor, to choose his own hospital. All of these things were factors that influenced us in drawing up the type of plan that we have for presentation to you.

After all of these discussions had taken place, you know that the Canadian Medical Association passed a resolution approving of health insurance, not of the particular plan that we had drawn up, but approving of the principle. That was something of importance. Before that was done, however, we felt that it was necessary to consult lay bodies as well as the professional bodies. The professional bodies might possibly have a bias in this thing. So we called in labour and obtained their views. Labour would prefer a national scheme, but is quite willing to accept the provincial plan, administration along provincial lines with dominion assistance. You will find at the back of this report a submission of each one of the various bodies that came to us and made submissions. Agriculture was called in through the Federation of Agriculture. Agriculture is very keen on a national scheme. Agriculture wants the major part in administration. Agriculture wants to place the medical, dental and other professions

in a subsidiary position, whereas we feel that they should all be equally represented in the administration. We think it is only fair that that should be the case. Industry was approached but did not make a submission. We also had submissions from the women's organizations throughout Canada—the National Council of Women, the Catholic Women's League, the Federated Women's Institutes of Canada, La Federation des Femmes Canadiennes Francaises. The list of them is here. I think that is what Mr. Mackenzie has submitted to me. Then we have the Canadian Life Insurance Officers Association. They have expressed themselves as being willing to help us in regard to public health, the preventive end, but they are not interested in medical care, and I cannot apparently convince them that the two are one. Our difficulty in the past has been this. The doctor has been interested in a case, in an operation. He knows nothing about statistics. He knows nothing about morbidity and mortality in the country. The hospital is interested in hospital statistics only for the purpose of comparison with other hospitals. The only people who study statistics in Canada are the public health officials. The public health officers have always been handicapped not only because of finances but because they have not had enough workers. We put in an amount in the bill to help young people to study public health. There has always been that handicap. So we propose under this scheme to bring the doctor into the preventive field. We want him as an adviser of the family, the medical adviser and the counselor. We want him to be responsible for the family when the family is apparently well. Whether we will succeed in doing that or not, I do not know. We want him to go into the family and examine the children, to examine them at school or wherever he can find them and see that diseased tonsils are taken out; to see, if the child is suffering from malnutrition, that it is properly fed; and to see, if the child needs an X-ray, that an X-ray is given that child. We have got to begin with children. We have got to build them up if we are going to have a virile people; and in order to do that we have got to bring the medical profession in with us, and we have got to have their fullest and most complete co-operation.

That is the situation, Mr. Chairman, in regard to the studies that have been made in regard to health insurance. If it is your desire and you wish me to do so—although Mr. Mackenzie covered the field very well, I thought, at the last meeting—I might outline briefly the plan that we have drawn up. I do not know if that is your desire.

The CHAIRMAN: Yes, it is.

The WITNESS: There are many types of health insurance, as I indicated at the outset, but there is only one type of health insurance that is of real value to a nation, and that is that type of health insurance which reduces morbidity and mortality, creates positive health and builds up a healthy people. We have tried under this dominion and provincial type of plan to produce that particular type of health insurance. We do not know whether we have done so or not. We feel that public health therefore and medical care should be one. Now, we think this; we go rather far, perhaps further than the provinces may sometimes be willing to go with us. We feel that the whole thing has got to be applied to all of the people of Canada, not to a small group. I am afraid I am tiring you, Dr. Bruce. However, the subject is so important that I will not make any apologies for it. The chairman in a moment of weakness suggested to me that I had two hours in which to present this subject and I am afraid I am taking advantage of you, sir, and of your committee.

We feel this, that this plan should be applied to all of the people of Canada. We think that is a fundamental and basic essential.

There are certain provinces which think that this should be limited only to people of small incomes. Why is health insurance made compulsory in most countries? In order to provide sufficient funds. Why should we give certain

privileges to those who have money? Why should they not be brought into this field? Do they not need public health and preventive medicine as much as anybody else? Does the parent with money pay much more attention to his child until the child is ill than does the man with the small income or of no income? He does not. He has got a responsibility to his family; in so far as health is concerned he can discharge that responsibility by provision of preventive services and medical treatment for his children along the lines that I have outlined. So we say that first of all it has to be compulsory because voluntary schemes have at all times been a failure. They have been a failure because there has not been sufficient money; because they have always been restricted in certain particulars; they have been applied only to small groups. They have had no influence whatsoever upon the health and the welfare of the people of the country, so that it must be compulsory and it should take in all the people.

The next point is that this plan is contributory. You know perfectly well that in this country we have not as yet developed the proper mentality. We feel that everyone should pay. When I first considered this problem I thought that it might be solved by establishing a basic rate, the same rate for everybody; as everyone would receive the same benefits then everybody should contribute the same amount but, of course, that was a physical impossibility. If you are going to bring in a whole community you will find there are people who are not able to pay the basic rate. Then I considered a percentage of salary, but when you come down into the low salary groups you find that percentage is very low. I was approached by a group from the province of Quebec who came to me voluntarily, the Hospital Advisory Group to the provincial government, and they said: "Why not adopt a system whereby each one will contribute according to his means. Let us take a servant girl. If you call her an indigent you make her a pauper. She may not be able to pay the full amount but she can pay something which may only be \$2, \$3, \$4 or \$5, but take it and make her independent. She is a part of the plan and a part of the scheme." I think perhaps that was the factor that induced Mr. Watson to draw up the system of collecting fees or premiums which was outlined by Mr. Mackenzie.

We propose that everyone will be taken in, rich and poor. Indigents will be included but not as indigents. Under the system of contribution there will be no indigents; there will be no paupers. That is what we propose. You will find that outlined in the Act.

What are the benefits? You cannot give a man or a child who is ill halfway measures. As I indicated at the outset, in England there are just as many people coming up to-day for medical care as in 1912 when the scheme went into effect. You must give them full and complete benefits. In many countries they give only the doctor and the drug. That is not sufficient. The individual must have a doctor; he must have his general practitioner, must place himself and his children in the hands of that practitioner, and that practitioner must have the privilege of calling in the consultant and the specialist and the surgeon and sending the ill individual to hospital, and that individual must receive all the hospitalization that is necessary.

We have made provision for the general practitioner, the consultant, the specialist, the surgeon, the hospital and the nurse. As to the hospital it will be a general ward, but there is provision there that any individual who prefers a semi-private or private ward may, by paying the difference, have a semi-private or private ward. Moreover, we go further than that. If the condition from which the individual is suffering is sufficiently serious to necessitate a private room, he will be entitled, or she will be entitled, to a private room. That, of course, will not happen to a very great extent.

So the scheme is compulsory, it is contributory, it covers all of the people. We hope the provinces will go far. It provides full and complete medical benefits.

I am not going to discuss in detail the method of contribution. I would prefer, if I may, Mr. Chairman, to leave that to Mr. Watson, who has worked out the details and who is much more familiar with them than I am.

Then there comes the question of administration. When considering that question it struck me, inasmuch as it was our desire to integrate public health with medical care, that administration might best be carried out through departments of health and that one of the duties of the department of health would be to collect statistics that would indicate the progress of health insurance from year to year. I was particularly anxious that the public health officer should play a part in the administration. He knows the statistics; he understands statistics; he knows how to analyse statistics, and he can tell from year to year whether or not the plans that we have laid are producing the result that we have in mind. A health insurance plan conducted without statistics is not as effective as it should be with regard to the control of that plan. I think you will agree.

As I pointed out earlier I was merely following along the same lines as the royal commission in 1926 in Great Britain and the recommendation of Sir William Beveridge and also information given us by the chief medical officer of Great Britain. They believe that their entire scheme should be under provincial departments of health. However, after discussing it with various professional and other bodies none of them was in agreement with me at all. They felt that there was very grave danger of political interference if the administration was put under the department of health, but they did permit me, Mr. Chairman, to place the administration from the national standpoint under the Department of Pensions and National Health—apparently they have a great deal of faith in Mr. Mackenzie—so the administration from the provincial standpoint according to this plan will be conducted by a commission composed of all those participating in the plan, labour, agriculture, industry, women's organizations, the medical profession, and various others, but only one man will be paid. It is headed up by a doctor and there seems to be some justification for that. We are told that a doctor is not a business man. Perhaps that is true, but it is only relatively true. Business men fit into certain categories. A banker may not make a very good butcher and a doctor might not make a very good banker, but a doctor knows health insurance. He knows the background and he has practised medicine. He knows the needs of the people in the public health field. He knows nursing and he knows hospitals, so that we have suggested in this plan that it be headed up by a doctor, and that the Deputy Minister of Health of each of the provincial departments of health be a member. The first step to be undertaken by a province after having adopted health insurance, we hope, is to make a study of the province. They must study all the facilities available. They must study their financial facilities, or whatever financial funds are available. Having done that the commission then sits down with the professions and others and they decide what benefits will be provided, where they will be provided and how they will be provided. It is quite obvious that it is not possible to introduce any one scheme of health insurance that can be applied to the entire country as a whole. Conditions vary to too great an extent in the various provinces. It would be a comparatively simple matter to introduce health insurance into Prince Edward Island where you have a homogenous population all engaged pretty much in the same activities, but when you come to the provinces of Quebec and Ontario there you find conditions are different. You have large cities with very large industrial areas but you have large rural areas, and treatment afforded people in the urban areas is bound to be quite different to that of the rural areas. In the cities you have all facilities available. You can give all the benefits that are laid down and do so immediately without any disruption of existing services, but when you go into rural areas then you have got to do something else. You have got to draw up a different plan. You have got to provide them with whatever is available until the time comes that you will be able to give them the entire service.

You can give them public health service. It will be the duty of the commission to divide the province up into health insurance and public health areas so that the two will be practically one, and where possible in outlying districts the public health officer will be the administrative officer.

There will be regional officers, of course, and regional nurses who will control the provision of practically all benefits so as to avoid abuses. We have estimated the cost. We have estimated it fairly high. We have gone out of our way to estimate it high so that there will be no mistakes and no misunderstandings, particularly on the part of the provinces, as to what it is going to cost them, but we feel—and I think we know—that it will not cost as much as we have laid down. Take, for example, a city. We think in a city that the full cost, the total amount provided will be expended because the benefits are readily available, but in the rural areas we will have to provide travelling nurses perhaps on a salary basis. We do not know just exactly what will be done but we have outlined roughly the cost.

Perhaps I should go further at the present moment with the administration. I have dealt with provincial administration to some extent. I think perhaps I should deal with federal administration before going into these possible costs in the rural areas and in the urban areas. We believe that the central administration can be carried out through a division of health insurance in the Department of Pensions and National Health. There is, of course, natural isolation. The provinces are isolated. They are separate from one another. Each one may be carrying out a different plan or a plan indifferently, and it will be necessary that there should be a planning of the spending of the moneys voted by parliament annually. We think that can be done through a division of health insurance in the Department of Pensions and National Health. We would like it there for one reason, and perhaps I should say for one reason only, and that is that we feel that the Department of Pensions and National Health should give leadership in the field of public health, and this is one very important way of doing it. You know that we have failed to give leadership in the past, not through unwillingness on the part of the ministers of health or the officers of the departments of health, but possibly through lack of understanding of the problem that confronted the country on the part of those—shall I be permitted to say without getting myself into any trouble right now—who legislate for the country. We have never accomplished a very great deal for the people. Now we think we can do it through that department. However, it will help to link up the public health end, and in addition to that we should like to have a national council of health insurance which would meet once or more than once a year here in Ottawa, and that would have on it representatives of all of these persons whom we have mentioned, representatives from each province, doctors, dentists, nurses, labouring groups, agricultural groups, and all of those interested in the problem. That would be the clearing house for information. Each year an agenda will be presented and each province will lay down what progress it has made in the field of public health and in the field of medical care. We therefore think that we can cover and overcome this decentralization by means of a dominion council of health.

There are many people, as you know, who think that we are making a mistake in carrying out our public health activities provincially and that we should centralize them all. But we who have been engaged in the field of public health for many years think that would be a very grave mistake; we think it would be an error that would prove injurious to the people of the country. We think that by a dominion council of health which deals with public health, and by the dominion council of health insurance we can link up the whole plan.

Let me go into these figures, if I may, for a moment. We have not attempted to estimate to the last dollar or to the last cent what health insurance is going to cost from the standpoint of treatment. We figured it out on the basis of present costs. We have not attempted to indicate what the provinces should do in the

way of entering into an arrangement with the medical profession, the dental profession or the other professions in regard to fees. The plan may be carried out on a fee basis or a capita basis or on a salary basis; it will be left entirely to the provinces to decide.

I have some figures here that I should be glad to quote to you. At the present time in the United States—this is the result of the study of 9,000 families, 30,000 odd people—42 per cent of the moneys expended for medical care goes to the doctor; in Canada approximately 44 per cent; hospitalization in the United States 16.3 per cent. We estimate that it will cost us 16.7 per cent in Canada. Nursing 8.1 per cent in the United States, 8.1 per cent in Canada; medicines, drugs, serums, vaccines, 12.9 per cent in the United States, 11.8 per cent in Canada; laboratory services, 2.2 per cent in the United States, 2.8 per cent in Canada; dentistry, 18.5 per cent in the United States, 16.7 per cent in Canada. We propose only to care for children and indigents.

That indicates that our figures run parallel. Now, there is one point that I should like to make in connection with this. There are perhaps people who think that by introducing health insurance plan the cost of medical services, dental services and other services will be lowered. If we are obliged to lower the standard of living of the doctor and of the nurse, who have a poor living as it is, and of the dentists and the druggists, and to lower the standard of the hospitals in order to provide health insurance, we had better not consider it at all. All of these people who provide services must be paid adequately and their standard of living must not be lower than it is at the present time. That is a *sine qua non* of a successful health insurance effort.

I have taken a great deal of your time, Mr. Chairman. You have been extremely kind; I do not think that there is very much more that I really need to say. It will be necessary to go into the Act. I might, however—I do not know whether it is your desire that I should go into the physical fitness aspect of it at the present time—

The CHAIRMAN: I think you had better, in a general way.

The WITNESS: I have already mentioned it. I thought I had a copy of the Physical Fitness bill here; I think it is probably in my bag. I would suggest, gentlemen, that in carrying out your studies you have recourse, as I presume you probably have already, to the study of public health prepared for the Royal Commission on Dominion-Provincial Relations by Professor A. E. Gower. I know many of you are familiar with it and I think everyone should be familiar with it because it gives you an excellent idea in regard to the deficiencies in the field of health in Canada and the measures that should be adopted for their control and what the provinces have done in that line.

By Mr. Cleaver:

Q. Would you give us the number of the appendix?—A. It is not included in the appendix; it is a study prepared for the Royal Commission on Dominion-Provincial Relations by A. E. Gower. Gower, when he started his work on this report came to our department. He visited the provincial departments, and we gave him all the help we possibly could. It is very comprehensive.

By Hon. Dr. Bruce:

Q. Is it in the ordinary Sirois report?—A. It is one volume separate, a separate and distinct volume of the Sirois report. It is very well worth reading. I wonder if it would be all right if I were to read these two pages?

The CHAIRMAN: Yes.

The WITNESS: This is a history, and a very brief one, of the national fitness movement in Europe. When the ministers of health met here October last I called to their attention a moving picture that was put on here in Canada by

Russia. Perhaps many of you have seen that picture. It was a very beautiful thing. I have no doubt they selected the finest athletes, both male and female, in Russia, and they marched through the Red Square. You will remember that some of them were playing football, mothers marched with their children on their shoulders, and others were magnificent skaters; there were boxers; there were bar-bell artists, dancers. I have never seen a more beautiful spectacle, and of course all of us asked ourselves why we could not get something of a similar nature in Canada; why had we not done something to organize the youth from the standpoint of physical development, from the standpoint of mental and moral development, and I found that Mr. Mackenzie was thinking at that time along the same line, and he was most particularly interested in the plan that was carried out in Europe.

Now, this is a memorandum that I have prepared:—

HISTORY OF NATIONAL FITNESS MOVEMENT

For years European countries, realizing the need of the physical development of youth, have conducted physical fitness activities which have as their object the physical, mental and moral development of youth. The activities include the physical development of the young in schools, colleges and universities through physical culture, the extension of playgrounds, and the provision of opportunities for sports and the development of sport activities under national auspices. In addition to physical development, the young are given opportunities for training in dramatics, in music, in art, and other cultural activities, and they do those things together. Nutrition has been associated with physical examination and physical culture in the schools by the provision of free meals and other methods.

Great Britain became interested in the subject of physical fitness early and sent a delegation to European countries to study their plans. The delegation included representatives of the Board of Education of England and Scotland, and organizers and directors of physical training. In the memorandum the Department of Health is not mentioned. It began its studies in November, 1936, and made a report which induced the British government to supplement existing health and educational services of the country by promoting a measure for the improvement of the national physique.

A memorandum explaining the government's proposals for the development and extension of available facilities under the title of "Physical Training and Recreation" was presented by the president of the Board of Education and the Secretary of State for Scotland to parliament by command of His Majesty in January, 1937. These proposals included the creation of national advisory councils for England (that is the line along which we are proceeding in Canada), Scotland and Wales, one of which was to be composed of men and women selected because of their knowledge and experience of the work of physical education and sports. It was also proposed that grants committees be appointed for England, Scotland and Wales whose members would be responsible for receiving and examining applications for grants and for making grants subject to the approval of the responsible minister. The proposals included the provision of regional and local committees. It was also proposed that there should be established a national college of physical training. The object was a two-fold one—first, to create in the public mind a realization of the value of physical fitness for its own sake, and, secondly, to provide facilities sufficiently attractive to make an effective appeal to the people of the country.

Meanwhile, at the 25th session of the League of Nations, the health committee when adopting its three-year plan of work considered that work in the field of physical fitness could be pursued successfully only by appointing a commission of physiologists to formulate scientific bases of rational physical

education adapted to different ages; but, before appointing the members of the proposed commission, the health committee considered it essential that a group of experts should be convened in order to obtain their views on the choice of subjects for study and the lines upon which the investigations should be conducted. The meeting of these experts was held in May, 1937, and their report communicated to a number of technical institutions and experts for their comments. The health committee took note of the report of the experts convened in May, 1937, and recommended that national committees on physical fitness should be constituted as had been done in the case of housing and nutrition and that an international committee be created comprising representatives of national committees. That was what was done in the field of nutrition and you know how successful that work has been throughout the world. Following this, the acting Canadian advisory officer at Geneva communicated with the Secretary of State for External Affairs of Canada reporting the activities of the health section of the League of Nations in respect of physical fitness in the course of which he called attention to the report of the Mixed Committee indicating that a disturbing situation existed in most countries regarding the physical fitness of large sections of the population. (So we were not alone in Canada in regard to defects of physical fitness. I think we are comparable to similar ethnological groups in other countries.) Later, a communication was addressed by the Director of the Health Section of the League to the Hon. Mr. Charles Power, Minister of Pensions and National Health, indicating the anxiety of the health committee of the League that national fitness education committees should be set up in as many countries as possible and requesting to be advised if the establishment of a national committee might be contemplated in Canada and suggesting that a representative be named to the International Commission on Physical Fitness without delay as it was the intention of the commission to convene during that year, namely, 1938. Unfortunately war put an end to all our thoughts and considerations at that time. I think that is right, Mr. Mackenzie.

Object

The object of the National Fitness Bill is to promote the physical fitness of the people of Canada through the extension of physical education in schools, universities and other institutions including industrial establishments; to train teachers, lecturers and demonstrators; and to organize sports and athletics on a nation-wide scale. The objective includes the development in persons of all ages of a desire for the well-being associated with physical fitness; to strengthen morale through a nation-wide programme; and to enlist the support of organized physical fitness agencies and that of individual volunteers. Physical fitness and health are closely related and associated with all those factors which make for good health. The programme includes games, athletics and sports, rhythmic, swimming, aquatics and life-saving, outdoor activities such as camping and hiking, everyday activities and skills.

The object is fostered by all who are interested in the field of physical education and chiefly by men in the physical fitness field who are associated with schools and universities and who are urging the dominion government to establish a physical fitness plan and provide funds to enable the provinces to establish a programme along lines similar to those which have been in effect in Europe for a number of years.

Method of Operation

A National Council on Physical Fitness will be established consisting of a director and nine other persons, each one of which will represent one of the provinces of Canada participating in the National Fitness Plan.

The only member of the council to be paid a salary will be the director; other members will be paid travelling and maintenance expenses while in Ottawa. To enable such council to function, there will be created a fund to be known as the National Fitness Fund.

It will be the duty of the council to assist in the extension of physical education; to encourage and correlate all activities relating to physical education; to formulate plans for training teachers, lecturers and instructors; and to correlate efforts of the provinces to organize activities to promote sports and to co-operate in the amelioration of physical defects amenable to improvement through physical exercise.

It is proposed that the Dominion shall contribute the sum of \$225,000 to the provinces and provide a sufficient amount to enable the National Council to carry out its activities—a total of \$250,000.

Attached is copy of the National Fitness Bill.

J. J. Heagerty,
Director,
Public Health Services.

P.S.—One of the first national fitness plans was that of Soviet, known as "Ready for Labour and Defence". Perhaps better known are the Hitler Youth and the "Kraft durch Freude", an offshoot of the "Deutsches Arbeitsfront". In Roumania the fitness slogan of the youth organization, "Straja Tarii", was work and joy for the country and the king. Czechoslovakia developed its successful programme of voluntary physical training through the Sokol and the Orel together with compulsory defence education of able-bodied youth in the "Branna Vychova". The Fascist youths were inspired to live dangerously in the "Balilla" and "Avanguardisti". In the United States the American Association for Health, Physical Education and Recreation concentrated attention upon the provisions of the Schwert Bill (Fitness for Defence).

And now, I won't go on with the bill because it will be necessary for me to read that in detail; but it has been drawn up along the lines of the last paragraph, indicated in the memorandum.

(Draft Bill appears as Appendix "B".)

And now, Mr. Chairman, I should think perhaps that outlines sufficiently the work that has been done by the committee and plans that have been formulated.

There is a suggestion that I would make, if it is agreeable to you, and it is that when particular and specific information is required that the members of the advisory committee who are familiar with the questions raised in respect to this particular section be called to give evidence, because they can put their finger upon the answer immediately. Were I to attempt to do so, I certainly would not be as successful as they would be. My business has been the planning and the getting together of the various people who have contributed and that is all. We worked as a team. This is not my report; it is the report of the Advisory Committee on Health Insurance.

Thank you very much, Mr. Chairman.

The CHAIRMAN: Thank you, Dr. Heagerty.

Are there any questions you wish to ask Dr. Heagerty?

By Mr. Shaw:

Q. In the course of his remarks the witness referred to tuberculosis having apparently increased since the outbreak of the war. I should like to ask Doctor Heagerty if he would attribute that to the lack of increase in the number of cases, or increase in the number of cases detected as a consequence of military examination of men entering the services?—A. I think we might answer that by saying, both; in all probability, both.

Mr. FULFORD: That is a safe answer.

The WITNESS: I wish that I could have been a lawyer, too.

Mr. MAYBANK: You are a pretty good one.

The WITNESS: I am not going to travel without you again. I think it may be attributed to both. You know that we are recommending that the civil service staff be X-rayed here in Ottawa. I saw some figures yesterday from the tuberculosis division of the province of Ontario which indicates to me that the situation in Ottawa is just a little bit worse than it is in any other part of Ontario. And now, we know that there is a great deal of tuberculosis among the young; that they are very susceptible to tuberculosis; and that when you bring them together the disease spreads very rapidly. When I was before the Civil Service Commission to plead the case for the X-raying of all civil servants in Ottawa, I was given a statement by one of the doctors of our department which showed that in a boarding-house where a young man went to board he acquired tuberculosis and when he was investigated in this province it was found that every other member of the family in which he boarded had tuberculosis. So it does spread very rapidly; and I suggest that rather indicates that we should have that done.

By Mr. Picard:

Q. Do we have provision in any other provinces for compulsory X-rays for everyone, similar to what they have in some of the states?—A. No, we have not.

Q. Do we have compulsory examination of food handlers?—A. No, not for tuberculosis; there is an examination from the standpoint of typhoid carriers, that is all.

Q. When you mentioned a cost of 30 cents per person, in the course of your statements, did that have reference to individual X-rays or the new system which is coming into practice of group X-rays? You know what I mean when I refer to the group system, three or four people taken together; is that what you meant when the cost was only thirty cents?—A. There are group X-rays carried out by the Department of Health. The X-ray is taken on a film, I should say about four inches long and about four inches wide but it gives a very fair picture. Of course, to X-ray a large group of people it is necessary that it should be carried out by some central authority organized for that purpose. But that is the rate they are charging in Ontario, and that is the over-all rate.

Q. Do you mean they can do it for the whole population at that figure?—A. Yes.

Q. Not by individuals but by groups?—A. It can be done by groups, and it is possible that in some places in Canada it is being done that way. The various industries in the province of Ontario have now become sufficiently interested to have all of their employees X-rayed, and the idea is spreading rapidly because it naturally reacts to the benefit of the industry as well as of the individuals.

Q. The point I sought to make by speaking of the group system was that I thought there was a system by which you could take a picture of a group of three or four standing alongside of each other.—Oh no, sir.

Q. I read an article a short while ago in which they refer to a process of that kind having been started and that the method was in use; that is the method of X-raying all the population in groups of four or five people at one time. As I understand from your evidence you say you use individual plates, one for each person. No doubt you have heard something about this paper process by which they can take a number of people together. Would that be practicable or would that reduce the cost?—A. I was aware of the fact that in Chile it was applied to the heart. It was a doctor in Chile who invented that system, but I did not know that it covered the lungs as well. I am glad to hear that.

Q. It is supposed to have been done in Cuba.

By Mr. Fulford:

Q. The figures you gave were those obtained from Dr. Briggs clinics?—

A. Yes; recently they were.

By Mr. Hatfield:

Q. You mentioned a charge of 30 cents in Ontario. Who is making this charge? Is it the hospitals?—A. No. This work is carried on by the provincial department of health through its division of tuberculosis control. There is not a profit, of course, in that charge. The province, if anything, will lose money on it. I think that is the minimum charge.

Mr. CLEAVER: Mr. Chairman, I just wish to ask as to whether it is your desire that we should now go into detailed questions or whether Dr. Heagerty will be available later.

The CHAIRMAN: He will be available later.

By Mr. Cleaver:

Q. Then I just had one question that I must plead ignorance on. Dr. Heagerty, in regard to the mortality rate on tuberculosis, you have referred to a rate of twenty-five in Ontario and eighty in Quebec.—A. Yes. We are so accustomed to dealing with these figures that I gave it in that way.

Q. Would you tell us what you mean by that?—A. Well, what we mean is twenty-five per 100,000 of population.

Q. That is a yearly mortality rate?—A. Yes. When we deal with the death rate of the population generally, or when we talk about the general death rate as being nine, it is nine per 1,000. But when we deal with individual diseases such as measles, chicken pox or tuberculosis, it is per 100,000. Otherwise the decimal would be very small.

Q. Have you a memorandum prepared that would indicate to what extent improvement would be shown by proper medical preventative treatment with respect to the different groups you indicated? Take first the situation in regard to the maternal mortality rate. You say now we are losing 1,000 mothers annually?—A. Yes.

Q. Under proper preventative service, how many would we lose?—A. I do not know whether it would be possible to give you those figures with a great degree of exactitude. But we can give you figures covering a long period of years. For example, I can tell you offhand that in the province of Quebec the death rate among children under one year of age in 1926, when health units were established, was 146. At the present time it is 72.

By Mrs. Casselman:

Q. You mean 146 per 100,000?—A. No. This is per 1,000. This is the death rate among children. The death rate in children is given per 1,000 live births. The death rate at one time in the province of Quebec was over 200 children per 1,000 live births. In 1926 it was 146 per 1,000 live births. Following the establishment of the health units, the reduction went on from year to year until at the present time the death rate is 75 per 1,000 live births. May I say this at this time. We have men in the department who are expert in these particular fields such as industrial hygiene, child and maternity hygiene. In order to obtain a very clear and concise picture of each set-up—and I think it is important that such a picture should be obtained—these men should be called rather than to rely upon me; because, as I indicated at the outset, I can give you only a general picture of the whole situation. I can tell you, for example, that since health units were established in the province of Quebec in 1926, the death rate from tuberculosis has been reduced 40 per cent. I can tell you that communicable disease deaths have been reduced 60 per cent. But these are only round numbers. But we do know definitely that it was due to the introduction of health units in that province.

By Mr. Lalonde:

Q. Has this Catholic bishops' committee made a final report concerning these Catholic institutions?—A. It is my impression that that study was made for their own information, solely to be informed as to what progress was being made. I would suggest that you have as witness here Father Emile Bouvier of Montreal. He is the head of this study that is going on. He is the chairman of it, I believe. Then I would also suggest that perhaps Sister Allard of Montreal—I think she is with the Hotel Dieu Hospital of Montreal—be called; also Sister Allaire of Mother House. I would suggest that they be called in and others who are familiar with that aspect of the problem. I think that should be very thoroughly threshed out. There are other religious bodies also of course, naturally, who conduct hospitals, who may be very much interested in this problem, to our knowledge. The Church of England conducts quite a number of hospitals, as you know, particularly in the north.

Q. You are under the impression that this committee will not report to our committee?—A. I do not imagine that that committee will report to you.

The CHAIRMAN: We can call witnesses. Are there any other questions?

Mr. SHAW: I do not want to occupy more time than would be considered fair, but I was particularly impressed with the statement of the doctor in connection with statistical evidence of the increase of disease or the prevalence of it in communities, if those communities are considered from an economic viewpoint, under prevailing conditions. It leads me to the conclusion that the success of a health insurance scheme will be directly proportionate to the stability or instability of the economy of the country at any given time. What I have in mind is this. In 1929 I believe the national income of Canada was about \$4,700,000,000. In 1933, it was down to \$2,600,000,000. In times like that, if we were collecting sufficient to finance a scheme of this sort, we would definitely be lowering the standard of living of the people, and from an economic point of view we would be conflicting with our activities from a medical point of view. That leads me to the question of contributory insurance versus non-contributory insurance. I am not prejudiced in this regard at all. I have an open mind. I have not come to a definite decision yet. The doctor referred to the pauper attitude of mind. I cannot agree that, just because a man is not making a direct contribution which is earmarked for that purpose, he is a pauper; to wit, our contribution towards the financing of the war through the payment of taxation. I would hate to think I am a pauper with respect to the part I am playing in assisting in financing the war, even though my larger contribution goes through taxation to the government. In that same connection, when you collect contributions from payroll deductions to go into a fund of this kind, I believe—and I stand subject to correction if I am wrong—that all this money is invested by the government in securities or in something else. In other words, you do not just simply accumulate large sums of money ready to be drawn upon to pay claims. The payment of claims is made out of current revenues. On the other hand, too, I daresay it will take thousands of employees to administer a scheme of this kind. So I wondered if it would not be practicable—and I read this recently in an article; it is not my own idea—for an act of parliament to be passed authorizing the government to withhold from current revenues sums which would be earmarked for the purpose of meeting the cost of such a scheme as this. I wondered if that would not be better than having all the complicated machinery necessary to make deductions from salaries and so forth, in order to finance a scheme of this kind. As I say, I am not prejudiced, and I would not expect an answer right now. We will no doubt discuss it later.

Mr. MAYBANK: Would not an appropriate answer be, "Yes, on the average"?

The WITNESS: The only comment I have to offer is this: we went into many of these questions that I have no doubt will be raised. We brought a very clever young man down from Western university, who spent last summer studying this entire plan. He is an economist. He drew up a national plan of health insurance, and he proposed that this national plan should be paid for on the basis that the rich should pay for the poor. He did not draw up a full and complete plan. He merely sat back and outlined the whole thing. We took it to the income tax. We did not take his plan but we discussed the whole question of collection by the income tax. The income tax pointed out to us that only certain people pay income tax; for instance, only married people who have income of over \$1,200. Therefore you leave out all married people under that. They go into the indigent class.

Mr. SHAW: I was not thinking necessarily of any particular form of tax to be used.

The WITNESS: This was one approach that we made, and the other was that single persons are taxed only if their income is over \$650. It was indicated to us it was a rather impracticable thing to do. However, I would like you to submit that question to Mr. Watson when he takes my place here as he is an actuary and will be more familiar with it than I am.

By Mr. McCann:

Q. Dr. Heagerty, in speaking with reference to administration, as I understand it you specified that there would be a national administration, and that then there would be a type of administration for each province. The question that I want to ask is, why is it necessary to specify the type of administration that the province should have when perhaps in their judgment some type other than a commission might better fit the needs of that particular area?—A. I think when you come to study the Act you will find that it is possible for the Governor in Council in conjunction with the Lieutenant-Governor in Council of the province on the recommendation of the Minister of Health to make certain modifications to this Act. It will not perhaps be possible to modify in respect of the benefits unless it is quite obviously impossible for the province to give all of the benefits, but the provinces will be given some latitude in the matter. It was necessary for us to indicate at least one plan or type of plan in the proposed bill.

The CHAIRMAN: Any other questions? Dr. Heagerty will be available every day we meet to answer any questions that may arise. We shall meet on Tuesday at 11 o'clock if that is satisfactory and hear Mr. Watson and others.

The committee adjourned at 12.45 p.m. to meet on Tuesday, March 23, 1943, at 11 o'clock a.m.

APPENDIX A

MEMORANDUM EXPLANATORY OF THE PROPOSED DRAFT FOR A
HEALTH INSURANCE BILL

1. The objects of the draft Bill are:—

(1) To place within the grasp of the people of Canada the benefits of a comprehensive scheme of health insurance, designed and organized for the prevention and cure of disease and the conservation of health;

(2) To assist the provinces in strengthening and enlarging their activities in public health and preventive work and services;

(3) To make a definite, and it is hoped, final, attack on certain health problems which continue to menace the welfare of the Canadian people; and

(4) To leave the way open for further developments of social insurance as and when such developments may prove to be practicable and desirable.

2. The general plan of the Bill for the attainment of these objects is to empower the dominion to enter into agreements with the provinces for certain specific purposes. For these purposes the dominion will make grants to the provinces. The purposes are: (a) Health Insurance, (b) Tuberculosis (treatment) (c) Mental Hospitals (treatment), (d) Public Health, (e) Venereal Disease (treatment), (f) Professional Training (public health work), (g) Investigations (public health) and (h) Youth (physical fitness), (Clause 3 and the First Schedule).

3. The prevention of disease and other public health work cannot be made really effective in the absence of health insurance, for the services of medical men and nurses are essential in that work and it is only through health insurance that areas outside the larger centres can be served in that work at a reasonable cost by medical men and nurses. But even in the larger centres, public health work and health insurance services must go hand-in-hand if the best results are to be achieved. Consequently the draft Bill requires that a province must make provision for using both the health insurance grant and the public health grant and not for either separately (Clause 3).

4. The reasons which indicate the advisability of grants to the provinces for health insurance and public health as against the alternative of a scheme of health insurance administered by the dominion together with grants to the provinces for public health work are:—

(1) The alternative would require an amendment to the British North America Act, which might be difficult, if not impossible, to get. Even if amendment were not necessary, full consideration of all of the facts and circumstances seems to indicate rather conclusively the advantages of administration within the provincial framework. This was the definitive conclusion of the Rowell-Sirois Commission (Book II, p. 42).

(2) Public health work and services have long been administered by the provinces and on the whole efficiently within the limits of the sometimes rather meagre appropriations for that work. Improvement in public health work along provincial lines seems clearly to be indicated rather than any alternative. To attain the best results, there has to be close co-operation between the administration of public health and health insurance. This co-operation can be made more effective, unified and purposeful if the two administrations work side by side under one control.

(3) There is now a good deal of statutory organization of the professions and of hospitals along provincial lines. Under these statutes the organized professions have important functions and duties to perform, all of which would readily fall in with the administration of health insurance under provincial control.

(4) Social philosophy and outlook differ widely from province to province. Account must be taken of these differences for both public health work and health insurance. To do so would be difficult, if not impossible, unless the two administrations were under provincial control.

(5) By reason of the spread in primary costs between the several provinces, the differences in the birth rate, and proportions of children to adults, and the proportions of the population at the advanced ages, there may well be a difference of as high as one-third in the costs of health insurance from one province to another. Under a Dominion scheme there would probably have to be uniform contributions irrespective of provincial costs, and this might be a serious source of perpetual friction.

5. The Bill prescribes conditions on which the Dominion may make grants to the provinces (Clauses 3 to 6, and the First Schedule). For purposes other than public health work and health insurance, the Bill provides, in general terms, that the provinces are to make statutory provision, satisfactory to the Dominion, for utilizing the grants (Clause 6). By reason of the greater importance attaching to public health work, and to health insurance, and for practical reasons, it has been deemed advisable that the statutory provisions should be indicated in a good deal of detail in the Bill.

6. For public health work, the provinces all have legislation in operation. Consequently it is sufficient to set forth a bill of particulars of the public health work and services which provinces should undertake within the framework of legislation they now have, amended if necessary, to meet the conditions for grants. Such particulars are given in the Third Schedule to the Bill (see also Clause 5).

7. For health insurance, the most satisfactory way to indicate the conditions to be complied with is to set down in legislative form a draft for a provincial Health Insurance Act. Clause 4 provides that the provincial health insurance legislation shall be in terms as set forth in the Second Schedule, "or substantially in the terms aforesaid, or in such terms as, having regard for all the circumstances, for the special conditions affecting the province as a whole, or any special areas in the province, may be accepted by the Governor in Council as a satisfactory practical measure of health insurance for the province". This gives all necessary flexibility for adapting the terms of the draft health insurance act to provincial requirements.

Some of the advantages of this procedure are as follows:—

(1) The adaptations of the draft provincial Health Insurance Act which may be necessary to meet conditions in any province will probably be relatively few. Consequently as high a degree of uniformity should result in the several provincial Acts as is desirable or practicable.

(2) With a draft Act to start with, the provinces should be able to enact their legislation with greater expedition than otherwise, for there will be a great saving of effort in preparing that legislation.

(3) As soon as the Dominion Bill is introduced, the terms of the proposed provincial health insurance legislation will be open to examination. It will probably be at least a year after the Dominion legislation is enacted before any province will get to the point of enacting its health

insurance Act. In the interim any defects, or any necessary improvements in the draft, should be discoverable and may be rectified by the provinces in enacting their health insurance Acts. This should prove a valuable safeguard in legislation so involved and of such far-reaching consequences.

8. Of the remaining provisions of the Bill, Clauses 7 to 14, inclusive, are concerned mainly with the terms which are to be included in agreements with provinces and with the execution of those agreements. Clause 16 provides for the creation of a National Council on Health Insurance consisting of the Director of Health Insurance of the Department of Pensions and National Health, the Deputy Minister of Health of each province, together with representatives of each of the professional groups concerned in supplying benefits under health insurance, of labour, of industry, of agriculture, and of women's organizations. The Council is to act as a clearing-house for discussion of all matters concerning health insurance, and in advising the Minister.

THE DRAFT HEALTH INSURANCE ACT (PROVINCIAL)

9. In the Second Schedule is given "A draft for a Health Insurance Act" to be enacted by a province. The terms of this draft may be considered under the following main heads: (1) the persons to be included; (2) the sources of the health insurance funds, i.e. the contributions; (3) the details as to benefits; (4) the general plan of administration; and (5) minor provisions.

10. It may be said at once that the draft provides for the insurance of all persons whose normal place of residence is within the province, without reference to any income limit (Clause 2). The benefits are as follows: (1) Medical, Surgical, and Obstetrical benefits; (2) Dental benefit; (3) Pharmaceutical benefit; (4) Hospital benefit; and (5) Nursing benefit (Clauses 27 to 32). These benefits are to be provided on a social insurance basis. The draft provides for administration by a commission (Clauses 35-41). Details under all these heads follow.

THE PERSONS TO BE INCLUDED WITHIN HEALTH INSURANCE

11. As has been stated, the draft provides for the insurance of all persons whose normal place of residence is within the province and who possess the qualifications prescribed in the Bill, i.e., the contribution qualifications (Clause 3). In some countries there are exclusions from health insurance on the basis of earnings or of occupation class or of both, and under some schemes the dependants of the insured person (the contributor) are also excluded. Such limitations may derive in part from the health schemes of insurance clubs and societies, in part from the relative ease with which contributions may be collected for wage-earners, and in part from the rather experimental and tentative nature of health insurance in the earlier days of social insurance.

12. Although certain practical difficulties might be circumvented by such limitations, other more important difficulties would be met. In Canada there is a continual shifting of persons between the employee classes on the one hand and the employer classes and own-account classes on the other; and in old age employment usually comes to an end. There are also shiftings above and below any assignable income limit. With any such limitations persons would be continually shifting in and out of insurance, and, if insurance were limited to persons in employment, those beyond the employable ages would all be out of benefit. Such a confused and unstable state of affairs would give rise to real difficulties in administration and would be quite unsatisfactory to the persons concerned. In any social legislation, it is not a question of avoiding all avoidable difficulties by limitations of the scope of the measure but rather of resolving the difficulties so that all undesirable limitations may become unnecessary and the maximum of advantages derived from the scheme.

13. Unless health insurance is extended to all classes and all ages, adequate public health work and prevention of disease cannot be made effective in areas beyond the larger centres except at a cost likely to be considered prohibitive, and even in the larger centres the effectiveness must leave much to be desired. As a consequence unnecessarily high mortality and morbidity would continue. In addition, all excluded classes would have to continue to resolve, unaided by co-operation with others, their own problems of prolonged sickness, hospitalization, etc.

14. The question of income ceiling arises to some extent as a matter of tradition in that in the past most health insurance schemes have provided very limited benefits, for example, medical and pharmaceutical benefits, benefits which the better-off classes might reasonably be expected to provide for themselves. In some schemes the sickness cash benefit is considered perhaps of greater importance than the health benefits, but the rate of sickness benefit is not high enough to be of much importance in the economy of those in the higher income brackets. Furthermore, the whole social and economic setting, the provision for hospitalization, etc., in countries with such schemes differ widely from Canada. With a scheme of health insurance providing complete benefits, benefits which will meet the essential needs of all classes, the whole question of income ceiling changes fundamentally. Moreover with the high taxation we now have, and which will probably remain high for many years, the proportion of the population which might, to-day, reasonably be excluded from health insurance on the basis of income must be rather negligible. Even if an income ceiling should be considered advisable or necessary in some provinces, it is quite unlikely that the same ceiling would be satisfactory in each such province. Consequently it would be rather inappropriate that any specific ceiling should be indicated in the dominion legislation.

CONTRIBUTIONS

15. It is of the essence of any scheme of social insurance that the right to benefit should derive from the fact of contributions having been paid by or on behalf of the person who is to benefit. Documentary evidence of payment of contributions constitutes the primary title-deed to benefit. Benefits based on taxation cannot be insurance benefits, and it is rather unavoidable that tests of means and other tests should be applied as a condition for receipt of social benefits grounded on taxation. Such tests necessarily reduce the benefits to the status of relief of distress. This is undesirable from all points of view.

16. Under social insurance the contribution may be paid wholly by the insured person or partly by him and partly on his behalf by his employer or the state or by both employer and state. Under Unemployment Insurance, for example, employers and insured persons contribute about equally in total, but employers pay the whole contribution of employees under the age of 16 years or earning less than 90 cents a day. The Dominion Treasury pays a contribution equal to one-fifth the total contributed by both employers and insured persons and in addition the whole cost of administration. Under health insurance in Britain, the employer pays the whole contribution if the earnings of the insured person do not exceed 3s. per day, and, for all insured persons, approximately 50 per cent in total. There is also a contribution by the government. Under employers' group insurance and employer-pension schemes, the employer contributes, usually, not less than 50 per cent of the cost. None of the circumstances just cited impairs in any sense the essentially insurance characteristics of the schemes mentioned. Contributions are always paid by or on behalf of each individual concerned and identifiable as having been so paid, and evidence of that payment establishes the primary right to benefit.

17. The health insurance benefits of the Bill will be financed partly out of contributions payable by those insured under the scheme (Clauses 4 and 5), partly by contributions by the employers of insured persons (Clause 8 (1)), partly by the province (on behalf of persons of very limited means (Clause 23 (2))), and partly by grants from the Dominion Treasury (Clause 4). The person who has the care and control of children will be entitled to the benefits of the measure for those children by virtue of his contribution (Clauses 3 and 5 (4) and (6)). But contribution is to be made for each adult dependant (Clause 5 (4)).

18. In settling on the details of contributions, there must be kept in mind at every turn the problems concerned with every aspect and circumstance of the administration of health insurance, and the records and accounts which will have to be kept, beginning with the collection of contributions and continuing through to the payment of medical practitioners, dentists, druggists, hospitals and nurses for each specific benefit, service, material and appliance furnished to insured persons identifiable in the records as having been entitled thereto on the basis of contributions. In addition it was considered important that the scheme of contributions should be such as not to stand in the way of the extension of social insurance to other fields if at any later time that should be deemed desirable.

19. For persons employed under a contract of service, or under a contract for services, the "stamp system," in principle as used for unemployment insurance, has no near competitor. It has been used in Britain for over 30 years, and Sir William Beveridge does not suggest any change in that respect for Britain. That method has been adopted in the Bill for persons employed under contracts as just mentioned (Clause 17; see also Clauses 8 to 20). These clauses follow substantially those of the Unemployment Insurance Act, and perhaps for that reason it may be unnecessary to summarize their terms.

20. For the whole of Canada the number of such contributors under Health Insurance would be over 3,000,000. In addition, the employer of a married man is to deduct from his earnings the full contribution for his wife (Clauses 5 (5) and 19 (1)). As a consequence contributions will be obtained by the stamp system by and on behalf of over 4,000,000 adults for the whole of Canada or from about one-half the adult population.

21. Some of the advantages of the stamp system are as follows: (1) It is the only system suitable for small employers, and their number is very great. For large employers appropriate adaptations of the stamp system may be made under the provisions of the Bill (Clause 17). (2) It avoids all the troublesome problems of accounting and errors in account numbers associated with pay-roll deductions. (3) It is automatic in its auditing, in that the employee will see to it that the employer stamps his book in order that he may get the benefit of the employer's share of the contribution.

22. It is the intention that the employee should pay a prescribed percentage, 3 per cent, for example, of his earnings for each pay period but not exceeding the contribution to be set forth in Schedule A of the provincial act. The difference, if any, between that contribution and the percentage contribution of the employee is to be paid by his employer (Clause 8 (1)). The employer is not, however, required to assist the employee in paying the contribution of any dependant.

Rates of contribution are not entered in Schedule A, for the reason that it is unlikely that the same rates of contribution will be appropriate in all provinces. For the same reason the percentage of earnings is not entered in Clause 8 (1). Solely for explanatory purposes, a copy of Schedule A has been prepared with illustrative rates entered therein in order that the principle may be better understood and considered in concrete although illustrative terms.

SCHEDULE A

Showing; (i) the amount of contribution payable by and on behalf of an employed person who has worked for an employer for the whole of a pay-period.

(ii) the yearly rate of contribution payable by and on behalf of an assessed person; and

(iii) the yearly rate of contribution payable in respect of a person, other than a child under the prescribed age, who is wholly dependent on a contributor. (In case of partial dependency the rate is to be proportionate to the degree of dependency.)

Class of Contributor	Pay-Period of Employer						Yearly Rate of Contribution
	Day	Week	3-times a Month	Fort-night	Twice a Month	Month	
	\$ cts.	\$ cts.	\$ cts.	\$ cts.	\$ cts.	\$ cts.	\$ cts.
Men and women who have attained the age of 20 years.....	*0 08½	0 05	0 72	1 00	1 08	2 16	24 00
Young men and young women who have attained the age of 17 years but not the age of 20 years.....	*0 04½	0 25	0 36	0 50	0 54	1 08	12 00
Boys and girls under the age of 17 years..	0 02	0 12	0 18	0 25	0 27	0 54	6 00

NOTE.—The rates of contribution are not to be understood as approximations to the rates which might reasonably be charged by any province; they are entered *solely for illustrative purposes*.

* The fractions of cents are automatically taken care of by using one-sixth of the weekly stamp the same as is done under Unemployment Insurance.

23. Persons who are not employed under a contract of service or under a contract for services, or who are not so employed for the whole year, are to contribute as "assessed" persons (Clauses 5 and 6). The object of the assessment is to ascertain whether the economic status of the assessed person is such that, reasonably, he should be required to pay in full the yearly contribution in Schedule A for himself and for his dependants, and, if not, the extent to which payment should be made on his behalf by the province (Clause 23 (2)). The basis of the assessment is to be the property, real and personal, of the assessed person and his income other than income from property (Clauses 7 and 21 to 25). As respects the great majority, it will be quite clear from a glance at their economic status that they will have to pay in full. Consequently, assessment in any detail will not be necessary in their case. In fact, most of them will undoubtedly remit their contributions in full and so avoid the trouble of giving details of their property and income. This is provided for in Part II of Schedule C. Assessment will be mainly a problem of assessing the poorer people. Their property and income status will be relatively simple, and consequently the problems of assessment should be simple.

24. The insured person will be assessed according to the following principles. His real and personal property will be deemed to yield him an income of a prescribed percentage of its value. Solely for illustrative purposes this may be put at, say, 4 per cent. That yield when added to the assessed person's income from sources other than from property will give his "assessed income" (Clause 22). If his assessed income is equal to or greater than a prescribed maximum, say, \$700, solely for illustrative purposes, for a person without dependents, he would pay the full annual contribution. If his assessed income were \$600 he would pay six-sevenths of the full contribution; if \$500, five-sevenths, and so on, the deficiency in each case being payable by the province. The prescribed maximum assessment applicable in the case of a person with one dependant might, for example, be \$1,200; with two dependants, \$1,600; with three dependants,

\$1,900; and so on. (These figures are solely for illustrative purposes and are not to be taken as indication of what in practice they ought to be in any province.) A person with an assessed income equal to or exceeding the maximum applicable in his case, having regard for the number of his dependants, will pay the full contribution for himself and his dependants. If his assessed income falls below the prescribed maximum applicable in his case he will be required to pay a proportion of the full contribution equal to the ratio of his assessed income to the maximum income applicable in his case, in principle the same as has already been indicated for a person without any dependants (Clause 23). Thus, on the basis of the illustrative maximum assessment of \$1,600 for a person with two dependants, if he were assessed at \$1,200 he would pay three-quarters of the full contribution for himself and the two dependants. Again, in order that there may be no misunderstanding, these are illustrative figures.

25. In order that real property may be valued uniformly throughout the province, provision is made for an "equalized" valuation once in every five years (Clause 21). As a basis for the equalization of assessment of real property values in the several municipalities, the province is to assess a sample of from five to eight per cent of the different parcels of land in different parts of each local government area, and the ratio of the total of the values of the sample as set by the province to the total of the values as set by the local assessors gives the factor by which to multiply the local assessed value of any property to get its equalized value for health insurance purposes (Clause 21).

26. The norm for an assessed contributor is the payment of his contribution, or his proportion thereof, for the full year. There could be no basis for adopting any alternative. Consequently for the employed person the norm must be contribution for the full year. In cases where employment for salary or wages does not extend to the full year the persons concerned will pay for the remainder of the year as assessed persons. In order that the number of such cases of assessment of such persons may be very materially reduced, it is the intention that the full year's contribution should be made in the first 48 weeks of employment in any year (Clause 6 and the proviso to 8 (1)). This will increase the weekly rate about 8 per cent but the reduction in the number of weekly contributions to be made will compensate therefor.

27. The contribution principles just outlined require each assessed person who is unable to pay the full contribution to pay in proportion to his means, the balance being made good by the province. As a consequence, no distinction need be made in the Bill between one person and another as respects his insurance status or treatment; all will alike be insured. This is desirable on many grounds, and some very troublesome administrative problems are automatically avoided, for example, the whole question of the status under insurance of indigents which would otherwise have to be faced. Under the provisions of the Bill the question does not arise; the province will take care of the whole situation by insuring indigents in the general Fund at regular rates.

28. Indigency, or near indigency, is not necessarily a continuing status. A person who may be required to pay little or nothing for one year may pay the whole or a substantial proportion of the contribution for the following year. In total a very substantial contribution will be made by those who do not pay in full, and without hardship on anyone. As matters now stand, any person seeking medical attention is expected to pay, and even the relatively poor usually pay something. The great difficulty is that they may have to pay a great deal all in one year. Under health insurance they will be required to pay a modest and reasonable contribution each year. The fact of requiring in total a uniform yearly contribution by or on behalf of each contributor will make for simplicity in many respects and will result in financial stability of the Fund. Stability of finance is a matter of great importance.

REGISTRATION

29. Under health insurance, persons will be insured as individuals; each person will select the practitioner by whom he wishes to be treated and he will remain on that practitioner's list until he selects some other practitioner (Clause 28 (2) (c)); treatment and other benefits will be for insured persons as individuals; payment from the Health Insurance Fund for benefits and services will be to medical practitioners, dentists, pharmacists, hospitals and nurses individually on the basis of specific services, materials and appliances for particular individuals. Individuals of the floating population in the province at any time from without will not be entitled to insurance benefits (and this will also be true of persons above the income ceiling in any province which may adopt a ceiling); all such persons must be readily distinguishable from insured persons for treatment purposes. Consequently it is clear that insured persons must be registered with the Health Insurance Commission of the province and their insurance status established; and there must be a record of that registration in the local administrative office of the commission, and the practitioners' lists of insured persons must be on record in that office.

30. Registration is provided for in Clause 7; the registration form is given as Schedule C. In Part III of that form is to be given data concerning the property and income of the person registering, to be used as a basis for his assessment if he should have to be assessed for his contributions; but in any case where it is clear to him that his economic status is such that he will have to pay in full, he will not be required to fill out that Part (Clause 7 (2) and Part II of Schedule A). Instead he may remit his full contribution and in general will doubtless do so.

HEALTH INSURANCE FUND

31. The establishment and management of this Fund (Clause 26) parallels substantially the provisions concerning the Unemployment Insurance Fund under the Unemployment Insurance Act.

BENEFITS

32. Persons qualified to receive benefit under the Bill (referred to as "qualified persons") are to be entitled to adequate measures for the prevention of disease and all necessary diagnostic and curative procedures and treatment (Clause 27(1)). Broadly stated, these benefits are to be administered under the following heads (Clause 27(2)) :—

- (a) Medical, Surgical and Obstetrical Benefits;
- (b) Dental Benefit;
- (c) Pharmaceutical Benefit;
- (d) Hospital Benefit;
- (e) Nursing Benefit.

Such special and technical procedures and ancillary services as may be deemed necessary to make effective the foregoing benefits in any case are to be provided as may be prescribed (Clause 27(3)). If in an emergency, or in other circumstances, it should not be practicable to furnish all of the benefits to all persons in need thereof, as far as may be practicable the persons most urgently in need are to receive first attention (Clause 27(4)).

33. To the extent that people may, to-day, be able to provide themselves with the benefits and services referred to in the preceding paragraph, they make their own arrangements; on the morrow of the coming into effect of health

insurance, arrangements will be made for them through the Health Insurance organization of the province. For an undertaking so great, the unavoidable and inevitable changes will, initially, be serious enough to manage. The benefit provisions of the Bill (Clauses 28 to 32) are so designed that, as nearly as may be practicable, on the morrow of the coming into operation of health insurance the people shall receive the medical and other benefits and services as nearly as may be in the same ways as they might have received them if, the day before, they had the where-with-all to pay. By adhering to this principle, as nearly as may be, there will be a minimum of initial confusion and misunderstanding on the part of the public, of the professions and of hospitals concerned in supplying the benefits, and on the part of those concerned in the administration. If any insured person should feel the need of treatment or advice, he will, under the provisions of the Bill, consult his own physician who, in his professional capacity and not as a servant or employee of the Commission, determine and administer the treatment if any should be necessary. All of the details are to be covered by appropriate regulations to be worked out in consultation with the professions and with hospitals.

34. Clauses 28 to 30 of the Bill provide that the Health Insurance Commission shall make arrangements with medical practitioners, dentists, pharmacists, hospitals and nurses for the supply of the several benefits. These clauses follow substantially the same pattern in that they conserve to insured persons certain essential rights touching the several benefits and at the same time they establish basic conditions on which the Commission may enter into negotiations with representatives of the several professions and with hospitals for the purpose of working out suitable arrangements for the supply of benefits. These arrangements are to be confirmed by regulation. The Bill gives ample authority for making arrangements to meet the varying conditions and special circumstances throughout the province. Then follows a summary of the several benefit clauses.

MEDICAL, SURGICAL AND OBSTETRICAL BENEFITS (CLAUSE 28)

35. The arrangements for medical, surgical and obstetrical benefits are to be made with practitioners in medicine, surgery, and obstetrics (referred to as "Medical practitioners" or "medical advisers") who are regularly qualified, duly licensed and in good standing in the province. Persons qualified to receive benefit will be entitled to adequate measures for the prevention of disease and proper, necessary and adequate treatment, attendance and advice from the medical practitioners with whom arrangements are made. As a basis for negotiations between the Commission and medical practitioners the main provisions in substance are as follows:—

- (1) Lists are to be published of practitioners who have agreed to attend, treat and advise qualified persons, showing in the lists the classes of services each practitioner is qualified and prepared to supply.
- (2) Each qualified person is to have the right of selection of a medical practitioner from the lists from time to time, subject to the consent of the practitioner, and the right to select specialists and consultants ordinarily after consultation with and on the recommendation of his medical practitioner.
- (3) Persons who fail to make a selection or have been refused by the practitioner whom they selected are to be distributed among the practitioners in the area.
- (4) The services of medical practitioners are to be organized in the prevention of disease and in the conservation of health and physical fitness.
- (5) Medical practitioners are to maintain adequate clinical records upon.
- (6) The remuneration of practitioners is to be by fees, capitation, salary, or any combination of these methods or otherwise as may be agreed

36. It is unlikely that the same method of remuneration will be satisfactory throughout any province. It may for example be necessary in certain areas to place practitioners on salary as an inducement to reside in the area, to the end that the people in the area may receive prompt attention. This will also be necessary for co-operation in the prevention of disease and in public health work.

DENTAL BENEFIT (CLAUSE 29)

37. The considered opinion of the Canadian Dental Association is that there are not enough dentists in Canada to supply more than a relatively small percentage of the dental services required by the Canadian people. Consequently the Bill provides that the Commission and the Dental Profession in the province shall work out a dental programme which is within the capacity of the dentists to furnish. That programme may in the first instance limit the dental benefits to children under a prescribed age. Persons above the prescribed age will continue to make their own arrangements for dentistry as at present. The intention is that the prescribed age should be increased as rapidly as the increase in the number of dentists may warrant and that eventually the programme will apply to the whole population.

38. The arrangements with dentists for carrying out the programme are to secure certain objectives substantially the same as those already summarized as respects Medical Benefit.

PHARMACEUTICAL BENEFIT (CLAUSE 30)

39. The Bill provides that the Commission shall make arrangements with retail pharmacists (including chemists and druggists) for the supply of proper and sufficient drugs, medicines, materials and appliances to qualified persons. In substance, the arrangements are to provide for (1) the publication of lists of pharmacists with whom arrangements have been made; (2) the right of any registered pharmacist to be included in the lists; (3) the right of selection of the pharmacist by the person for whose benefit the prescription is given; (4) the pricing of prescriptions by a central board, bureau or committee for the whole of the province in accordance with a tariff agreed upon between the Commission and the pharmacists.

HOSPITAL BENEFIT (CLAUSE 31)

40. Hospital benefit provides for all necessary treatment in hospitals (including convalescent homes), other than treatment for tuberculosis or mental illness. Treatment for these latter will be otherwise provided for by the provinces. The main provisions which are to be observed in making arrangements with hospitals are in substance: (1) the publication of lists of hospitals showing the classes of services and treatment each hospital is capable of providing and authorized to provide, the hospitals being "non-profit voluntary", municipal, provincial government and dominion government, except as may otherwise be prescribed; (2) treatment to be available only when ordered by the medical practitioner of the insured person; (3) the right of selection of the hospital by the person to be treated; (4) the right of the hospital to determine the medical practitioners who may treat patients therein; (5) the compensation of hospitals to be in accordance with either of two general plans or otherwise as may be prescribed (Clause 31 (1) (f)); (6) general ward service only unless in any case semi-private or private ward service is determined to be essential to the welfare of the patient, but any person is to have the right to semi-private or private ward services, if available, on payment of the difference in charges. There are a few other minor administrative provisions.

NURSING BENEFIT (CLAUSE 32)

41. "Necessary nursing services" only are to be provided. The main provisions which are to be observed in making arrangements for nursing services are: (1) The arrangements are to be made with organizations representative of registered nurses, but may provide that, in special circumstances or for limited or special duties, nursing services may be supplied by persons of lesser training and experience, the names of such persons to be entered in lists showing the classes of duties and services which may be provided by them in the special circumstances. (2) Nursing service is to be available only when ordered by the medical practitioner. (3) As far as may be practical, nursing service in each local area shall be provided through the local organization of registered nurses. (4) The conditions of service, hours of work, and methods of remuneration are to be subject to reconsideration and revision from time to time. (5) The accepted standards of nursing training and nursing services are to be maintained.

SPECIAL PROVISIONS AS TO BENEFITS

42. If in any region or area the Commission should find that it is not reasonably practicable to administer any or all of the benefits under the general arrangements for administration, the Commission may make other arrangements suitable to that region or area, or put into operation a modified or alternative scheme of benefits (Clause 33).

43. If, in respect of any injury, sickness or disease, any person receives any of the benefits provided in the Bill, and is entitled to recover under Workmen's Compensation, or otherwise, compensation or damages for that injury, sickness or disease, provision is made for reimbursing the Health Insurance Fund for the cost of the benefits so received by him (Clause 34).

GENERAL ADMINISTRATION (CLAUSES 35 TO 41)

44. It will be perceived that in supplying benefits the great bulk of the administrative work will arise locally, the routine and details not differing more than is necessary from the ways in which people now receive services in the event of ill-health or accident. An important part of the central administration will be the enactment of suitable regulations making effective the arrangements worked out with the professions and hospitals for the supply of benefits, and the revision of those arrangements and regulations from time to time. There will be administrative duties and functions of another character than just indicated, namely, the administrative and routine business of collecting contributions, keeping track of insured persons in local regions on each practitioner's list, maintaining records, accounts, etc. What has just been said will serve to show how essentially different the problems of administration will be from those which confront a workmen's compensation commission, for example. Nevertheless the consensus of opinion appears to be overwhelmingly in favour of administration of health insurance by a commission. Many of the groups and classes who will be affected by health insurance consider it imperative that they should have representation on the commission. The advantages of such representation are obvious. It is also obvious that the constitution, personnel and procedure of the Commission should be adapted specifically to the functions to be performed under health insurance, and that even a commission of three sitting continuously would be too top-heavy for several provinces, if not for all, and at the same time would not be large enough to meet the legitimate demands for representation thereon.

45. Having regard for the administrative problems of health insurance and for all the other circumstances, including the wide differences there are between one province and another, the commission provided for in draft is to function

substantially as a board of directors of a business corporation, but with the powers, duties and responsibilities of a commission, the Chairman being continuously on duty and paid a salary. The other members are to receive such remuneration and travelling expenses in connection with the work of the commission as may be approved by the Lieutenant-Governor in Council (Clause 37). The Chairman is to be a doctor of medicine having practised for at least 10 years (Clause 35 (2)); he is the chief executive officer of the commission and, in accordance with the regulations and the directions of the commission, is to have supervision over, and direction of, the work of the commission (Clause 36 (1)). The Provincial Health Officer is to be a member of the Commission (Clause 35 (3)). The remaining members of the Commission are to be chosen by the Lieutenant-Governor in Council after consultation with organizations representative of medical practitioners, dentists, pharmacists, hospitals, nurses, insured persons, workers in industry, employees, agriculturalists, women's organizations, and of such other groups and classes as may be determined from time to time by the Lieutenant-Governor in Council but at least one from each of the professions or groups or classes. The Chairman is to hold office for such period as may be determined by the Lieutenant-Governor in Council but not exceeding ten years, and the other appointed commissioners for two, four or six years (Clause 35). The Bill provides that the commission shall meet twice each year and at such other times as may be necessary.

46. It may be noted that this is the form of administration proposed in a draft Health Insurance Bill of the American Association of Social Security published in 1942.

47. If in any province it should be felt that a small commission, say, of three devoting their whole time to the duties of office would be more satisfactory, it is thought that there should be an advisory council representative of the groups and classes mentioned, the advisory council to meet at prescribed times and at other times as required.

48. Any person appointed to any executive, administrative or other position requiring professional training and experience in medicine, in dentistry, in pharmacy, in hospital work, or in nursing, is to be chosen after consultation with representatives of those professions or of hospitals as the case may be (Clause 40).

ADMINISTRATIVE REGIONS

49. In order that public health work and health insurance may be administered economically and efficiently, and with the greatest advantage each to the other, the draft provides that the province shall be divided into administrative regions, the same regions to be used for both purposes (Clause 42). In settling on the boundaries, all relevant circumstances are to be taken into account. Fairly generally more than one local government area will be included in a region. Provision will be made for using the public health personnel and facilities available in the regions and for apportioning the cost among the local governments within the region. In the event of objection from any local government, the question is to be settled by arbitration.

COMMITTEES

50. For an undertaking affecting so many people and interests as health insurance will, it is necessary that the Commission should have the help of many committees in order that all points of view may receive proper consideration. For the purpose of consultation concerning regulations and arrangements for the supply of benefits to insured persons, the commission may recognize any committee which satisfies the commission that it is

representative of hospitals or of the members of any of the professions concerned in supplying benefits (Clause 45). Dentists and pharmacists are organized under provincial statutes; consequently the executive bodies of those organizations are each given power in the Bill to appoint a committee for the above mentioned purposes (Clause 45 (3) and (4)). Local committees may be appointed where local interests are concerned but only after consultation with the provincial committee.

51. A general power is given to the commission in Clause 46 to establish all such committees, councils, etc., as may be found necessary for consultative, advisory, administrative or executive purposes.

QUESTIONS, COMPLAINTS AND DISPUTES

52. Provision is made for settling all questions, complaints and disputes without resorting in the first instance to the courts (Clauses 47 and 48).

53. Questions whether any person is an "employed person," or concerning (1) who is the employer of an employed person, (2) the rate of contribution of any employed person or an assessed person, and (3) whether any person is qualified to receive benefit, are to be determined in the first instance by the commission, with power to revise a decision on the basis of new facts. If any person is aggrieved by a decision of the commission he may appeal to a judge in chambers whose decision shall be final (Clause 47).

54. The commission, medical practitioners, dentists, pharmacists, hospitals, nurses and insured persons will all be concerned in the administration of health insurance. Differences of opinion on many matters will arise, and consequently complaints and disputes will be inevitable. Clause 48 provides that these shall in the first instance be referred to committees. In the case, for example, of a complaint against a medical practitioner by an insured person, the committee will be composed in equal numbers from medical practitioners and insured persons with an independent chairman. If a hospital, a nurse and an insured person were concerned in a dispute, the committee would be chosen in equal numbers from insured persons, nurses, and from a panel for hospitals, with an independent chairman. Regulations are to prescribe the classes of cases which the commission may settle on the basis of the findings of the committee and the classes of cases in which an appeal may be made, but in all cases where the right of any person or hospital to continue to supply any benefit or service is in question provision must be made for appeal. All such appeals are to be referred to an appeal committee consisting of a barrister at law or a solicitor and at least two persons selected in manner prescribed from the profession of the person concerned or from representatives of hospitals, as the case may be. The Commission shall, in the manner prescribed, give effect to the recommendations of that committee.

CONCLUSION

55. There are many other largely routine provisions which, although important, need not be summarized here.

56. An important characteristic of the Bill is its flexibility. Under its provisions every condition in any province can be met, and there will be no occasion for the fundamental problem of bringing health insurance benefits to the people being held up at any point by reason of inadequacy of the provisions of the Bill or of any unduly arbitrary provisions therein.

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SESSION 1943

HOUSE OF COMMONS

SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 3

TUESDAY, MARCH 23, 1943

WITNESSES:

Mr. A. D. Watson, Chief Actuary, Department of Insurance, Ottawa.

Dr. J. J. Heagerty, Director of Public Health Services, Department of
Pensions and National Health, Ottawa.

OTTAWA

EDMOND CLOUTIER

PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



ORDERS OF REFERENCE

WEDNESDAY, 17th March, 1943.

Ordered—That the names of Messrs. Maybank and Fulford be substituted for those of Messrs. MacKenzie (Neepawa) and Telford on the said Committee.

Attest.

ARTHUR BEAUCHESNE,
Clerk of the House.

THURSDAY, March 18, 1943.

Ordered—That twelve members shall constitute a quorum of the said Committee.

Attest.

ARTHUR BEAUCHESNE,
Clerk of the House.

MINUTES OF PROCEEDINGS

TUESDAY, March 23, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Breithaupt, Bruce, Casselman, Mrs. (*Edmonton East*) Claxton, Cleaver, Cote, Diefenbaker, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Howden, Hurtubise, Lalonde, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIlwraith, Maybank, Mayhew, Slaght, Veniot, Warren, Wood and Wright.—31.

Hon. Ian Mackenzie read a letter from F. P. Varcoe, Deputy Minister of Justice, stating that no correspondence had been exchanged between the Department of Justice and the Provincial Governments respecting the passing of Health Insurance measures.

The Minister also made a statement respecting conflicting press reports concerning government policy on Social Security.

The Chairman called to the attention of members of the Committee the address made by Rt. Hon. Winston Churchill and suggested that they study same.

Mr. A. D. Watson, Chief Actuary, Department of Insurance, was called, examined, and retired.

Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, was recalled, further examined, and retired.

The Chairman informed the Committee that the Dominion Council of Health would meet in Ottawa on the 29th, 30th and 31st of this month, and that the provincial Deputy Ministers of Health would be available to inform the Committee as to the social security measures in force in their respective provinces. It was agreed that they should be heard.

On motion of Mr. Cote, the Committee adjourned, to meet again on Tuesday, March 30, at 11 o'clock a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

MARCH 23, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Before proceeding this morning the minister, Mr. Mackenzie has two statements he wishes to make.

Hon. Mr. MACKENZIE: Mr. Chairman, Mrs. Casselman and gentlemen: at our last meeting Mr. Diefenbaker moved:—

I would therefore move that the Department of Justice or the Department of Pensions and National Health be requested to produce copies of all communications, letters, and so on, that have been written by and on behalf of the federal government to each of the provincial governments, which have been designed to secure or in connection with the securing of the cooperation of the provinces in the passing of health insurance by parliament.

I have the following letter from the deputy minister of the Department of Justice:—

Ottawa, March 23, 1943.

To The Departmental Solicitor,
Department of Pensions and National Health:

I have for acknowledgment your letter of the 19th instant with reference to the proceedings of the Parliamentary Committee on Social Insurance and the motion made by Mr. Diefenbaker for production of copies of all communications, letters and other documents written by and on behalf of the Federal Government to each of the provincial governments in connection with the securing of cooperation of the provinces in the passing of health insurance by parliament.

From a search of our records covering the past fourteen years there would appear to be nothing to indicate that this department has had at any time correspondence with the provincial governments on the subject of the passing of health insurance by parliament.

F. P. Varcée,
Deputy Minister.

That is from the Department of Justice. As far as the Department of Pensions and National Health is concerned, there are a few communications addressed to the provincial ministers of health, not to the prime ministers of the provinces; one is an invitation to them to attend a meeting on the 21st of September, 1942, in the Daly Building to discuss the general principles of health insurance and the departmental proposals as far as they had at that time been developed.

Mr. DIEFENBAKER: What date was that?

Hon. Mr. MACKENZIE: The letter was dated September 11, 1942. I have a copy of that letter here. It was not marked confidential and it was sent out to the provincial ministers of health, and as a result of that letter they attended—I think from every province—the meeting held here in September of that year. The only other communication was subsequent to that meeting when I addressed a letter to the same ministers of health which was marked confidential, and which

I am not prepared to produce. However, I may say that the general purport of it was asking them for their reaction to the discussions which took place at the conference here at Ottawa; and I think I may tell you that the general trend of the replies was very cooperative.

Apart from these two communications, there is nothing on file with the department dealing with constitutional jurisdiction which was raised by Mr. Diefenbaker. The question of constitutional jurisdiction has not been raised either by the Department of Justice or by ourselves; is that clear?

Mr. DIEFENBAKER: Yes.

Hon. Mr. MACKENZIE: The second statement I would like to make is this:

Since I tabled certain reports with this committee a week ago there have been various conflicting accounts in the press, speculating upon government policy. On the one hand are predictions of immediate action; on the other, predictions that nothing is to be done until after the war. I may say, Mr. Chairman, that there have been no such decisions by the government either for or against. This select committee is entirely free to make such reports and recommendations to parliament as it chooses. There shall be no suggestion of dictation from the government.

Government policy was set forth in the speech from the Throne, from which I quote the following sentence:—

My ministers believe that a comprehensive scheme of social insurance should be worked out at once, which will constitute a charter of social security for the whole of Canada.

Emphasis was laid first on employment, secondly on freedom from fear and from want.

Announcement was made of the intention to appoint committees of the house to consider these matters, and particular reference was made to the intention to submit for "study and consideration" the establishment of a national system of health insurance.

The committees foreshadowed in the speech from the throne have been established, and three reports were placed before this committee for study and consideration. These reports were:—

1. A report on health insurance, prepared pursuant to specific instructions embodied in an order in council dated February 5, 1942, by an advisory committee set up under that order in council;

2. A draft bill for a national physical fitness programme, prepared by the Department of Pensions and National Health;

3. A survey of what would be involved for Canada in an all-embracing programme of social security. This report was prepared at my request by the Research Adviser of the Advisory Committee on Reconstruction.

The three reports are before this committee and can be dealt with by the committee as it chooses. Except as regards approval of the general principle of promoting physical fitness, which underlies the draft bill on that subject, they have not been considered by the government. The documents submitted were presented to the committee solely to be helpful to it in its deliberations upon the subject matters referred to it by the house.

However, as a member of this committee, I should be gratified if it were to find it possible to make a report—

- (a) surveying the various measures of social security in the dominion and in the different provinces, with the costs thereof, and additional measures being presently considered;

- (b) indicating additional fields which are not covered and an estimate of the possible costs involved;
- (c) reviewing the implications and costs in a co-ordinated scheme with reference particularly as to how best to effect—
 - 1. efficiency in administration;
 - 2. economies in financial outlays involved, and suggesting how the several measures and costs should be allocated as between provinces and the dominion;
- (d) recommending which measures should be given priority.

Since I have referred to certain conflicting conjectural statements in the press, I should like to add a word of appreciation to the newspapers and their correspondents for the admirably clear and comprehensive coverage of the documents and statements presented to the committee last Tuesday. These have placed before the people of Canada a very excellent account of the study done to date along these lines.

That is the whole of the statement, Mr. Chairman.

The CHAIRMAN: Thank you, sir.

Following that statement by the minister, I would call the attention of the committee to the statement of Prime Minister Churchill on Sunday last. Doubtless many of you, or perhaps all of you heard it; if not it is available in printed form in the press of yesterday. I think our study here is somewhat similar to the situation he discussed. We should, I think, study carefully the implications of that statement, and follow the suggestions made in the minister's (Hon. Mr. Mackenzie) statement with regard to the study of the various measures now in force in several provinces with a view to possible greater co-ordination; and, as well, a study of the costs and the distribution of the costs.

This morning our first witness is Mr. A. D. Watson, Chief Actuary, Department of Insurance. Mr. Watson, please:

Mr. A. D. WATSON, called:

The WITNESS: Mr. Chairman, members of the special committee on social security: I thought it best to commit to writing what I am going to say because, if I were to attempt to proceed otherwise there are so many interesting by-paths on the way that I should probably go down a good many of them and perhaps go down some from which it would be hard to get back again. I want to follow along the main trunk line if I can, without wasting your time.

Now, in the hope of being some help to the committee, I should like, if I can, to disengage from the welter of current usage the meaning of the term "social security," to indicate something of the development of security in times past and of the conditioning forces and difficulties with which security has had and will probably have to contend. Then I should like to say something concerning the fundamental differences, the advantages, disadvantages and limitations, of the measures which have been specifically proposed for attaining social security. Finally, I should like to say something about the place of priority which, it would seem health insurance should hold legislative-wise, and the reasons therefor, leading up perhaps to a consideration of some of the terms of the proposed draft for a health insurance bill. I shall not attempt to be either complete or exhaustive, but rather suggestive.

To make effective progress in considering measures of social security, it is necessarily important to be clear concerning what, specifically, "social security" has come to mean to-day, and it is no less important to be clear concerning the advantages and the limitations of the instrumentalities, the ways

and means, by which it is usually proposed that we should proceed on the road toward social security.

Manifestly social security is an attribute, or a desired attribute, of the environment in which we live, but our very use of the term, social security, implies the existence of other categories of security in that environment. For convenience in the present context, all these other categories may be classed under the one head, "general security." As a background, I shall examine very briefly the historical development of general security in human society in the hope that by doing so we may at the same time arrive at a clearer understanding of social security and its dependence on general security. General security must include national, political, economic, industrial and civil security, and, at least in democratic countries, it implies freedom in the political, civil, economic, industrial, social and religious sense. So much for general security.

Whenever as a consequence of an accident, ill health, disability, loss of work, or inability to work, death of the bread-winner in a family, the attainment of old age, or for any other reason, an individual becomes a charge, in whole or in part, on his community or the state, rather than on his family or friends, we are perhaps agreed that a social problem has arisen. For centuries past, in most countries supposed to be more or less civilized, these and other social problem cases have been taken care of in some fashion in public institutions, under poor laws, and under other like laws. However necessary and useful such institutions and measures may have been, and may still be (reformed, humanized, brought up to date), they do not constitute social security measures as understood to-day. But measures taken by the community or the state with a view to providing in a regularized way, as a legal right and without any consequent loss or change in civil status, for the personal or family hardships and distress which follow on the occurrence of contingencies which beset our daily lives, are to-day referred to as social security measures, and to the extent to which these measures may be effective, they result in what seems, generally, to be understood by "social security".

I think perhaps the distinguishing characteristic there is that whatever is done under the head of social security there should be the legal right without the consequent loss or change of civil status.

Going back a step further, any measures taken to prevent the occurrence of accidents, to improve the health of the community, to increase and regularize work, to educate the people and to increase their industrial skill, efficiency and resourcefulness must also rather directly contribute to social security. Nevertheless it does not appear that any of these measures are to-day considered to be specifically within the social security field; they may be classed as general security measures. The fact is that all, or practically all, measures which add to general security have also a direct bearing on social security. Consequently, to bring the problems of attaining social security into perspective it will be an advantage first to examine, however briefly, the problems which the attainment of general security have presented and do present to-day.

The very fact of the continued existence of more or less organized human society throughout the ages implies the cooperation of human beings, and some resultant degree of solidarity and security, within the framework of that society. The form and content of that solidarity and security have depended, and depend to-day, on many inter-related, ever-changing factors and forces—are in fact manifested by and through these factors and forces—as, for example, the social and political organization of the state, the system of land tenure and the arrangements for the cultivation of the soil; economic, industrial, commercial and mercantile development; religious outlook and traditions; educational, scientific and technical advancement; development in administrative honesty, competence, resourcefulness and technique; all being end-results of the activities,

interests, genius, characteristics and endowments of the people themselves and of the conditioning factors and forces of climate, geography and natural resources. And to a quite extraordinary extent, human affairs have been conditioned and shaped by what, humanly speaking, can only be described as accidents, oftentimes of trifling import in themselves—accidents either transmuted by some lucky turn or by the natural genius of the people, or accident which proved too much for the human community concerned, perhaps due to lack of leadership equal to the events at some critical juncture. Along with the accidental may be classed temporary expedients which have become permanently incorporated into the political, economic, industrial or social structure—expedients which in some cases have proved of more enduring value than “the best laid plans of mice and men”. It has been said with much truth that “nothing is so permanent as the provisional”.

To add point to what I have just said, the origin of the principle in our form of government of the ministry advising the King, or his representative, is a striking illustration. Prior to the reign of George I, the King presided over his ministers in council to consider matters of state and to arrive at decisions. George I understood English so indifferently that it was useless for him to sit with his ministers, and so the custom grew up of the ministers sitting by themselves in council, and later advising the King of the decisions they had reached, and that custom has long since become constitutional, the result of a wholly fortuitous circumstance. This principle is regarded as the very key-stone in the arch, or one of the many key-stones, of our form of government. Perhaps on no other basis can monarchy and democracy be successfully harnessed in government, enduringly, and to the great advantage for security. Constitutional planners may well “consider and bow the head”.

I think I am accurate in that statement. I recall reading it a good many years ago in a book by Andre Maurois called “The Miracle of England.” However, if our constitutional authorities present do not agree with it, I shall be glad if they will correct it, and I will revise it.

Except for relatively short periods in human history, the working out of security has had to contend with political, industrial, economic, religious and social unrest, strife, crises and revolution within the state; frictions and open conflict with other states. The world, more particularly the modern world, has been in a perpetual state of rebuilding, and along with this rebuilding there has generally been a shifting of the centre of gravity—or perhaps it should be “centres of gravity”—both within national economic systems and in the world as a whole; and there is no real evidence that these things are near an end or will end with the present conflict. What I have just mentioned gives in briefest outline, but necessarily in very general and inadequate terms, the conditioning variables within which security throughout the world, including social security, has had to be—has still to be—wrested in some fashion, in some degree, from insecurity and uncertainty. In making social security plans for the future, perhaps it would be just as well not to postulate any higher degree of general security for the next generation than we have known for the past generation or two.

At this point I should like to indicate the more specific instrumentalities, the organized ways and means, by which security has been, and is still, worked out.

Although such security as has been attained in human society has necessarily been worked out by human beings in co-operation, it is hardly possible to exaggerate the importance of the individual himself in working out security for himself, and thus adding to the security and good of his fellows within that society. Anything which weakens the sense of responsibility and purpose of the individual, in providing for himself and those dependent on him, is

not for his good nor for the good of society. Social security measures should, as far as practicable, be framed to strengthen, not weaken, the responsibility and purpose of the individual. Specifically, the individual works out security for himself in certain rather individualistic and personal ways, as for example, by maintaining his health; by acquiring knowledge and special skills which make him useful and resourceful in the social and economic system; by saving and acquiring property and insurance. None of these things would, of course, be possible or have value to him except for co-operation within human society.

The next factor of importance is that relatively communistic unit at the foundation of our so-called individualistic society, the family. The importance of co-operation and sacrifice within the family group in attaining security throughout the ages, in facing hardships and difficulties, as a bulwark against misfortune which may befall any member of the family group, need only be mentioned to be understood. Family cohesion and strength has persisted because it has answered, and can answer as no substitute can, some of the deepest and most intimate human needs in the most dire circumstances. Those who would substitute the state in larger part for the family, or weaken family loyalties in favour of the state, are on unsound ground in the long run. What is required is to support and encourage family cohesion, responsibility and effort so that it may be more fruitful. All security measures should be designed with that end in view.

Am I making myself heard at the back of the room?

Mr. McCANN: If you would speak a little louder, it would be much better.

The WITNESS: From very early times co-operation began in other natural groups of persons, as for example, persons of the same craft, occupation, industry, trade, race, religion. Such co-operation may have been organized and active or merely occasional or mainly a matter of common understanding or custom. Co-operation through ad hoc societies and organizations for specific purposes, as for example, fraternal societies and orders and mutual benefit societies, has been of enormous social and economic significance. The benefits provided by such societies and organizations have very generally been specifically social benefits. In addition, such societies have proved a useful training ground for their members in self-government and responsibility, and in education concerning the difficulties in doing things in an organized and co-operative fashion. An increasingly important part has been played by public and private welfare societies and institutions.

The services and advantages accruing through corporate enterprise, being yet another form of co-operative effort—banks, insurance companies, and other financial institutions; trading, commercial and industrial companies—have greatly increased the means for obtaining employment and security.

Finally, security has been increasingly extended in most countries by government through enactment of humane, protective, restrictive and safeguarding laws. These laws in general function so unobtrusively that we forget the great security and social benefits which we derive from them every day. In addition there have been increases and improvements in the innumerable services and facilities which can best be undertaken by government, including local government, in the general interest, the most important of which relate to education and health. And in recent years many governments have added cooperative security under government control, supervision or authority, for, generally speaking, the classes of the population which could not protect themselves to the best advantage against the major vicissitudes of life, namely, accidents, ill-health and invalidity, unemployment, old age, death. In some of these fields voluntary cooperation either could not function well, or at best would function with such difficulty and

so incompletely as to still inevitably leave over many major social problems. This is more specifically the field for social security measures.

From what I have said up to this point it will be seen how large a place direct cooperative effort has in securing us against the insecurities of life.

In stressing the importance of cooperation, I do not wish it to be understood that I am confessing to any political allegiance.

Much as government has contributed directly and indirectly to security and to social security, there are limits to what can be done through government action. I am sorry, Mr. Chairman, that my reading is interrupted by my coughing, but I have had a cold and my throat is not just as good as it might be. The minimum functions of government may be set down as the protection of life and property, administration of justice within national boundaries, and defence against attack from without. While at times in some countries there may have been a disposition to restrict governmental activity as nearly as possible to these minima, it does not appear that government, anywhere at any time, has succeeded for long in doing so. The fact is there is no important phase of human activity or interest which has been free at all times and in all countries from government intervention. Over long periods of recorded history, both internal and external policies of some governments may in large part have been determined by, for example, religious issues; racial and religious persecutions; possession of the Holy Sepulchre; royal marriages, dynastic succession; foreign conquests; colonial possessions; trading rights and interests in certain external areas; control of the seas; piracy—issues not very closely related to social security as such, nor to security in general. Extremely complex forces, sometimes seemingly blind and inscrutable forces, have shaped or controlled government policy and action throughout the ages and will probably do so for a long time to come. Hence it is unlikely that social security will have the “right of way”, as it were, except as a gradual process in the building of a saner world. Theoretically—that is to say, leaving out of account human dynamics, or dynamic individuals, within and outside the state—it should be possible in a relatively self-contained economy to capture and stabilize security on the basis of current knowledge and technique, but it would probably at best be static—a sort of South Sea Island civilization with little vitality in it.

Except as a matter of poetic licence, it cannot be said that one increasing purpose runs through the development of human security. The pendulum has swung rather widely, and those living through each particular epoch may have felt that it was just about the most insecure in human history. Nevertheless the modern world has become security conscious and that consciousness has in some minds manifested itself mainly as an urge to see the whole complex problem of social security placed on the shoulders of the national government with a scheme of so-called “adequate” benefits for every contingency. A rather rampant idea, variously expressed, has been abroad for some years to the effect that the state may, as it were, pack itself on its back and march off to planned security, prosperity and happiness. In a book published about five years ago, a professor of economics put it thus: “Social security should involve more than a mere protection against the risks of modern life—it should also represent a positive concept embracing a consolidation of gains and the establishment of a rich normal life.” This confused notion that “a rich normal life” may be secured for the individual, not so much through and by himself as in spite of himself, by the state, is a capital error. The best that society can do is to give the individual a fair chance; perhaps it should be a fighting chance, for most of the great ones of the earth have had to fight against important disabilities and misfortune.

The problems of human relationships and affairs are too complex to be satisfactorily amenable to state treatment alone. The attainment of sound social security must rest on a broader base than the shoulders of the national govern-

ment. It would appear to be a problem for the individual, for the family, for private cooperative attack, for welfare organizations, and the multiplicity of stabilizing agencies at work in our environment. Lastly, there are some parts of the problem which can best be undertaken—perhaps can only be satisfactorily undertaken—by the state. That there are limitations on what the state can usefully undertake follows in part from the fact that state action must necessarily be taken pursuant to specific legislation. But the complexities of human needs are too great to be answered, except in part, by any legislation, however flexible. Hence there will always remain a great deal to be added to social security in all the other possible ways we have known.

In putting forward social schemes there may be a disposition to speak in terms of the passing away of old things; of giving a new deal; of the dawning of a new day. Such slogans may have some value if they do not unjustifiably create expectations or exalt emotions, but it seems unlikely that any method, technique, device, instrumentality, which has ever proved really useful in attaining security or any benefit for society will ever be superseded, or rendered useless, in our increasingly complex human relations. It is more likely that the new and the old may usefully and profitably function side by side, whether for economic utility, ornament, pastime or sport; and these latter also have their economic utility as well. It is illuminating and suggestive, and perhaps it ought to be sobering as well, to recall that, notwithstanding all of the advances in mechanics and in scientific invention, we still use the sickle and the scythe; that candles come into their own whenever the electricity fails; that to light our cigarettes we strike fire from flint many times a day as the savages did and as our forefathers did in this country less than one hundred years ago, and even archery still has its use in modern society as a sport. In travel, and in transportation and communications, by land, water and air, the ancient and most modern—the birch-bark canoe and the giant airplane—find their usefulness and utility side by side in answering to human needs. The world would be much the poorer from any attempt to get along without the ancient ways and means of doing things. This is all intended as a moderating hint against the easy faith that the state can take on the whole problem of social security, and against the danger of destroying the old in favour of the new. If the state should attempt to do so it would probably be at a great economic, political, social, and moral loss, and loss of security and freedom as well in the long run.

With the increasing complexities of advancing—or perhaps we should say “modern”—civilization, and the consequent advance in administrative honesty, competency, versatility and technique, an increase in social legislation may reasonably be looked for in most countries, both within fields already entered upon and in new fields. Nevertheless it is well to keep in mind that the risk of error is great in any legislation, but nowhere so great as in social legislation.

Social legislation deals with human beings, individually and collectively, in some of their most subtly elusive life-relationships; not with producers or consumers, importers or exporters, employers or employees, proletariat or capitalist, brain-workers or manual-workers, working-classes or leisured-classes, nor yet with human statistical averages, nor any of the other entities, data or concepts with which discussions and conclusions in economic theory are likely to deal, but with human beings; and human beings with their loyalties, allegiances and prejudices, with their political, psychological and other traditional backgrounds, are liable to react with a seeming lack of logic to social enactments however well-intentioned. Even if the reaction should be on the whole favourable, there is liable to be something of value drop out of our culture and civilization—a loss, maybe, of individual and family responsibility; a destruction of social cement which gave stability and meaning to our environment and

continuity with the past. Social and other heritages may easily be damaged by a bad approach in social legislation. Viewed mechanically, monetary and industrial phenomena and functionings, and even our social and economic life-relationships, may appear simple enough. They are nevertheless extremely complex and difficult to manage legislative-wise. Hence the importance of making sure that, on balance, the legislation may in fact be a real advance—and not a step backward or too violent a break with what we have.

Social legislation may apply to some defined class of citizens, or may virtually affect the whole nation, as in education and health measures, or may apply to those who voluntarily avail themselves of it. Where social legislation is to apply to a particular class, the delimitation of that class is generally a real difficulty. This is one important reason why a specific contribution, or payment for services rendered or advantages enjoyed is so desirable wherever it is practicable to proceed along those lines. In addition the moral effect of a specific contribution is always sound.

Where, for example, due to old age or misfortune the resources of the individual are insufficient for his needs, a serious burden may be thrown on family, relatives and friends, and recourse to private and organized charity may be necessary. The burden thus largely falls in a haphazard fashion on certain members of society and must be met by them mainly as a current expenditure and often on a low and uncertain standard. From the cost point of view, there can of course never be any doubt of the capacity of the national government to take over the burden thus falling on certain individuals and place it on the broader shoulders of the general taxpayer, provided it is substantially the same burden that is transferred and not, as is so generally the case, a burden which proceeds to grow apace once the transfer takes place. There may be sound economic justification in making such a transfer, if administrative difficulties which inhere in the particular scheme are not too serious—an important reservation—for if a substantial proportion of worthy and reasonably industrious citizens are unable under the national economy, and the ancillary facilities afforded them, by their own individual effort to provide for their wants throughout life and in old age, while the national wealth increases, there would appear to be, *prima facie*, justification for holding that the class was not getting a reasonable share of the national dividend, or that the ways and means for making the best use of their share are not readily available to them or that they fail to use the available means. In any event the organization or the encouragement of their individual efforts is clearly justifiable, if the administrative difficulties can be overcome. Notwithstanding what has just been said, the advantages of getting at least some contribution from those directly to benefit from any scheme of social legislation are scarcely deniable; and the general taxpayers' shoulders are not as broad as we sometimes think they are.

Initially, perhaps social legislation cannot usefully attempt to go beyond organizing the efforts of the individuals concerned by affording new, additional or improved channels through which they may, in a corporate or cooperative manner, with consequent increased economy, strength and purposefulness, if founded on a sound basis in a practicable field, obtain, on balance, more consistent, satisfactory and uniform results for themselves and remove the hazards and uncertainty associated with the diffused, wasteful, and sometimes purposeless efforts of individuals. The object should, in general and as far as practicable, be to assist and make purposeful, not to supplant, the traditional and customary efforts of the people themselves. The field must be well chosen and the plans well laid. Any attempted advance must on the whole be in harmony with the socio-economic development of the nation and its administrative capacity. It is unsafe to aim at the desirable standard of good but rather

at the standard that is economically practicable, that can be paid for and soundly administered. To attempt something more may be to attempt to set up and maintain unsound economic situations within the state.

A reasonably safe starting point for any proposed cooperative social effort would seem to be to plan to spend something about of the order of the expenditure by the class or group concerned on the service or benefit in their own more fitful and wasteful fashion. (Incidentally, that is approximately what is intended should be spent on health insurance; not some extraordinary new expenditure; that is, spent by people of all classes on health insurance.) While the standard may not be high, if it is effectively attained a useful and sound foundation will be afforded on which individual and family effort and initiative may build with better hope of success. Once a scheme of social benefits is well established, it is relatively easy to increase standards should it then seem practicable and desirable so to do. If something too ambitious should be attempted at the start, it may collapse of its own weight or it may worsen the plight of those intended to be helped, as for example slum clearing schemes which result in housing beyond the rental capacity of those displaced, thus resulting in slums elsewhere. If by state or other aid, the advantages accruing to the class to be benefited are out of balance with the economic system generally, an increase in the numbers of the favoured class may take place by transference to that class, offsetting to some extent the benefits intended for the particular class as may result, for example, under schemes of unemployment insurance. If the benefits should be really very substantial, the consequence might be most serious.

Legislation affecting a large class of citizens in any important way, no matter how well considered it may be, is bound to cut across established channels of services, functions, traditions and customs. The dislocation following on any really sudden voluntary change-over in socio-economic customs or fashions in wants or in the satisfaction of wants would be no less serious than changes brought about by legislation. This indicates the importance of avoiding all unnecessary dislocation.

As a concrete objective standard of the *modus operandi* of social advance in some if not in all fields, so far as advance may be susceptible of aid through state action, perhaps the development of education by the state is, on the whole, as safe a guide as any, notwithstanding the valid criticism which may be directed against the development and the present status. At one time the full responsibility for education rested, and in large part still rests and, to be effective, must always rest, on the individual and on the family. State education is merely an extension of the educational functions of the family. The state has never attempted to cover even all of the formal education anyone should have, nor to control all the educational institutions within the state. State education has never been "adequate" in many respects, but nevertheless has generally afforded a foundation on which individual and family initiative and resourcefulness might build with better hope of success. Perhaps that may be the ultimate which can usefully be attempted by state action in most social fields for a long time to come. The facilities of state education have, generally, been equally available to rich and to poor, but they are more valuable to the poor in that, without them, the poor might get very little education at all. There has been a gradual, sometimes uncertain, development, beginning with elementary education in rudimentary form. There has been progress and advancement depending on the physical equipment which the people could pay for and the quality of the teaching staff available. To-day in some countries the higher education of the most promising students is assisted to such an extent as to make it virtually free. In primary and secondary schools, we have free books and other supplies, and, for those in need, free milk and luncheons. The concrete factors entering into the solution

of the problems of state education at any stage—qualified teachers, adequate buildings, equipment and costs—have always imposed realistic thinking on those responsible for educational policy; but where the proper solution of any social problem is conceived in terms of money payments, particularly if the money is to be found by the national government for some objective in the distant future as, for example, old age pensions, there is danger of economic and fiscal thinking becoming nebulous if it does not cease altogether. People who regularly think in wholly realistic terms concerning the finance of schools, church, or local government, can cite with epic enthusiasm the unlimited taxing powers of the national government as justification for unloading all costs of all social problems on the national government to the end that there may be secured to the individual “a rich normal life.”

With what I have already said as some sort of background, I should like briefly to analyse the characteristics of the two types of measures usually put forward, to-day, for attaining social security rather than general security namely, (1) the establishment of social insurance funds for the protection of the persons insured against distress, and (2) relief of distress out of public funds in cases of proved need. Where the second method is established on a highly regularized basis it is more commonly denominated “public assistance”, but the principle is the same although the administrative outlook and technique may differ considerably.

In some quarters the use of the terms “social security” and “social insurance”, and perhaps also “public assistance”, is so confused that the first two at least seem to be used rather interchangeably, and the latter two are used without any attempt to exemplify their fundamental differences. With such confusion in mind, it is not possible that any serviceable conclusions should emerge except as a matter of luck. As I have just indicated, social insurance and public assistance are fundamentally different technical instrumentalities, measures or approaches through which social security, or a degree of social security, may be attained. It is of prime importance that the essential characteristics of each of these measures should be understood, not that the one is the right approach and the other the wrong, or that one is to be preferred to the other, but to the end that the appropriate type of measure may be relied upon for each particular purpose in view at each particular juncture. I shall analyse the characteristics of the second method first.

Under that method, the standards of benefit in any defined category, whether in the event of sickness, unemployment, widowhood, invalidity, old age . . . , and the detailed circumstances in which each class of benefit may be paid may be defined in specific terms.

There may in addition be a general provision for the relief of cases of proved need not covered in any of the specific benefit categories. The tests of need to be applied may vary for each type of benefit, i.e., the tests to be applied in the case of an old age benefit may differ from the tests in case of sickness or unemployment. If the tests are the same for every class of benefit, the scheme is likely to be what we understand by “public relief” rather than “public assistance,” i.e., there would be no specific categories of benefit; the object would be to relieve distress whatever the cause.

Under measures of the relief or public assistance type, the only persons who need to be considered, administratively, are those who make application for benefit, and the main administrative problem is to determine the degree of need in each case and to pay accordingly within the rules. It is true that under more strictly relief schemes benefit may be in kind or partly in kind. By reason of past experience with relief measures in Canada, the technique of organization, administration and supervision, whether of relief or of public assistance, is fairly widely and fairly well understood. Such measures

could probably be put into operation quickly to meet an emergency, almost as quickly in fact as the public funds could be made available.

Under measures of this type which are intended to be a permanency in the social security structure, as, for example, under our scheme of old age pensions, the fact that any resources of the individual are taken into account in reduction of his benefit tends to destroy any incentive to save on the part of those who think themselves likely to come within the scheme, or if they do save some of them are likely to find ways of disposing of their property so as, technically, to qualify for benefit. Manifestly it is quite unsatisfactory that a claimant for benefit under any measure of social security should be induced or encouraged by reason of the qualifying conditions to make himself appear as poor as possible in order to secure benefit or the largest benefit.

As a matter of fact, in New Zealand all the cash benefits under social security are of the public assistance type. There are means tests for all those benefits with the exception of the universal old age pension, which has been in operation for a long time.

Properly speaking, there is no insurance in their social security measures. Incidentally that was true under the old age pension scheme in Britain from 1908 to 1925, at which time they placed it on a contributory basis. Now by far the larger proportion of persons who qualify for old age pensions do qualify by reason of having made contributions.

Social insurance, on the other hand, like other insurance, is a means whereby, by payment of premiums or contributions into a fund, provision is made against defined future uncertainties which beset the daily lives of those who contribute to the fund. The uncertainties insured against under social insurance may be, for example, unemployment, sickness, disability, old age, death. The circumstances in which benefit will be paid in each case, and the amount of the benefit, must for insurance purposes be precisely defined, to the end that, on a claim for benefit, it may be determined whether the contingency insured against has occurred and if so the benefit which is to be paid. Any misfortune which may occur to the insured person outside the contingencies insured against cannot attract benefit. A social insurance fund is not a part of the public funds; it is solely for the protection of the persons insured, the same as any other insurance fund.

Social insurance, like other insurance, is not properly describable as a means for effecting a redistribution of existing income, or as a transference of income from the wealthier to the poorer classes, but rather as a means of distributing loss, or the burden of misfortune, among the whole insured group; and in that way the income of those who suffer loss may be to some extent maintained. But to think of a social insurance fund as an instrumentality for the redistribution of income is to place the emphasis in the wrong place and to get started on the road to confusion. To construct a social insurance scheme with that object in view would be to abandon every proper principle and purpose of social insurance. It is true that there may be a contribution by the state out of general taxes, but the purpose of that contribution is certainly not a redistribution of income. Under unemployment insurance, for example, the contribution by the treasury equals only one-sixth of the total contribution, which is probably not more than the indirect benefits which unemployment insurance will bring to the general taxpayer. But in any event it can have no important effect in redistributing income. Social insurance does not consist in the creation of a fund into which persons in need may dip according to their needs, but rather a fund out of which on the occurrence of certain well defined contingencies specific benefits are payable to the insured persons who have contributed to the fund and have suffered loss or misfortune by reason of that occurrence.

Social security ideas are now an international currency, but they require close examination before acceptance as sound currency, and when they are stated in poetic terms they had better, first, be rendered into prose for examination. The National Resources Planning Board of the United States in their recent report declare for a "dynamic economy," and they state: "The three factors—democracy, dynamic economy, and peace—never in the history of man have they been united in a political system." A "dynamic economy" may perhaps be translated into the vernacular as an economy which "goes places." In any event social insurance, like other insurance, has nothing dynamic about it, but rather the reverse. The object of insurance is to give confidence, certainty and security, and without these business and enterprise certainly will not "go places." It is not clear that social security has anything to gain on balance from a dynamic economy however interesting may be the dynamics to those who produce them.

As contributions have to be paid for protection against future contingencies, it is essential that all persons within the insurable field should be identifiable in advance so that contributions may be collected from them or on their behalf, or the due payment of the contribution secured. As contributions are required to be made to secure protection against future contingencies, it is imperative that no inquiry should be made concerning the resources or the needs of the person insured on a claim for benefit. All that is required to be known is that the claimant was in good standing insurance-wise in accordance with the rules at the time the contingency occurred. Thus the settlement of claims for benefit is much simpler than in the case of public assistance or relief, and the person insured receives the benefit as a right acquired by payment of contributions and without any humiliating disclosure of his personal or family resources or needs; and if he has been able to acquire any additional resources on his own account, so much the better for him in the event of misfortune.

From what has been said, it will perhaps be clear that the problem of the putting into operation of a scheme of public assistance is much simpler, and can be effected much more quickly, than for schemes of social insurance. But the substitution of public assistance for social insurance, where the setting up of social insurance is practicable, is open to the fundamental objection that it tends to destroy incentives to thrift. In addition, the administration of means tests is resented by those claiming benefit and is distasteful to those who administer benefit. Nevertheless, to meet an emergency it is hardly practicable to escape the application of public relief or public assistance technique in some form; and even with as complete a system of social insurance as can be worked out, there will still be cases of misfortune not covered by insurance.

The problems of organization and administration of most schemes of social insurance are very great and should be undertaken only with the greatest circumspection and care. Each plan of social insurance has special problems of its own which will require to be narrowly taken into account in the administrative approach, outlook and technique. The issues involved as regards unemployment insurance, for example, differ absolutely and fundamentally from those of sickness insurance or health insurance. Again, where the insurance contract is one of long term as, for example, contributory old age pensions, or benefits payable on death, issues of another order arise out of the simple fact that long-term insurance contracts are involved. In the first place, after contributions have been paid under such contracts, even for a short time, vested interests become established which make such contracts irrevocable in a sense in which that word does not apply to short-term contracts. There is really only one direction in which long-term social insurance contracts can properly be amended and that is in the "bigger and better" direction at the expense of the state; hence the need to be certain, initially,

that the details are along sound lines. For long-term contracts there are also questions concerning the reserves to be accumulated and the investment of the funds. There are differences of opinion on these questions, due largely, it would seem, to misunderstanding, but these misunderstandings should be cleared up lest any such plan should be established on wrong lines. Perhaps it is sufficient here to say that when the government enters into undertakings, other than the current year-to-year fiscal undertakings for ordinary purposes of government, involving trusteeship, then those undertakings should be managed separately from the ordinary affairs of government as though by a separate instrumentality or corporation. Those who claim that it in fact makes no difference either way can hardly possibly have any effective argument against proceeding on the basis of trusteeship.

The problems of each plan of social insurance are so complex, composite and varied, that it is hardly practicable, all views to the contrary notwithstanding, that all plans, or even several plans, should be successfully started at one time under one administration. Where this has been attempted it will probably be regretted for a long time to come once they actually find out that they have got off to a bad start. This is not to suggest that plans should not now be made for any and every scheme of social insurance thought desirable; what is suggested is that there are natural priorities in putting the several schemes into operation. I shall refer to this again. A scheme of social insurance should not be thought of as something to be taken up by the roots every little while and planted over again with variations; it should be planned and thought of as something of a permanency in the social and economic system.

To add point to some of the points I have tried to make with reference to schemes of social insurance, we may consider the case of unemployment insurance. The Unemployment Insurance Act was passed August 7, 1940. Its general framework and method of administration was modelled closely on the British Act. The plan of organization and administration of the British Act was well understood and had been set out in great detail in a number of publications. Nevertheless, it was only by well nigh superhuman effort that in Canada the Commission was ready to begin the collection of contributions by July 1, 1941, about eleven months after the Act was passed. But the collection of contributions is only a part, and in some ways a relatively small part, of the problems of administration of unemployment insurance and not the most difficult. There is also the placement work, the payment of claims, inspection, etc. So far as placement work is concerned, that was well understood from past experience of employment offices in Canada, so that new ground did not need to be broken in that respect.

As respects claims, under the benefit formula of the Act an insured person cannot qualify for benefit until after he has made contribution for 180 days. Thus no claim could arise under the Act until February, 1942, and since then a relatively small number of claims have occurred. This has given the administration an opportunity of learning, on the instalment plan, the technique of settling claims and everything which goes therewith. It may therefore be said that the setting for putting unemployment insurance into operation was on the whole favourable in that the difficulties were spread over a considerable period. Nevertheless, it is probably true to say that it will take several years before all the administrative problems will have been reduced to a reasonably satisfactory routine. So much for the difficulties of putting one form of social insurance into successful operation.

Incidentally, what I have just said indicates that the putting into operation of a scheme of unemployment insurance is not the proper technique for

meeting an unemployment emergency. It would take about three or four years before such a scheme could count for much in taking care of unemployment.

There may be some fairly good reasons for thinking that, for persons under unemployment insurance, insurance against time lost through sickness (cash benefits) might very well be administered by the Unemployment Insurance Commission. I am not saying that this is so; I am merely using it to illustrate a point. But the problems of organizing and administering sickness insurance, more particularly the settlement of claims, are so fundamentally different from the problems of organizing and administering unemployment insurance that if the two types of insurance benefit had been undertaken at one and the same time by the Unemployment Insurance Commission, I feel satisfied the resulting confusion and multiplicity of divergent problems and interests must have been just too great. The consolidation of separate schemes of social insurance which have been in operation for some years is one thing; the starting of two or more schemes all at once under one administration is another thing. This does not seem to be sufficiently understood or understood at all.

The proposal has been made in Great Britain that there should be a great deal of consolidation. Their schemes are well established and the technique of their administration is understood. It is quite another thing to consider consolidation with a green staff for administration.

When the administration of unemployment insurance is on a surer basis, then it would be safe to take on the administration of sickness insurance, if it should then seem advisable that sickness insurance should be administered along with unemployment insurance. Again I do not say that it ever will be advisable for it is not my place to do so; I am merely illustrating a point concerning insurance schemes. There may be better reasons for thinking that wage-earners who are not under unemployment insurance should also have the protection of sickness insurance if and when it comes to be established. If that should be the view, then the machinery of the Unemployment Insurance Commission would be inadequate for the collection of contributions.

It is likewise for contributory old age pensions. It is not my place to say whether we should or should not have contributory old age pensions, but there have been many favourable pronouncements on the subject over the past 35 years, the most important and authoritative being by the Quebec Social Insurance Commission in 1933. Not only did they declare unequivocally in favour of contributory old age pensions but that "all legislation failing to consider the rural inhabitant, and especially legislation dealing with old age which loses sight of this object, would be legislation which could be termed unjust." In addition they declared that for the farmer the state should pay the employer's share of the contribution.

It seems undeniable that a scheme of contributory old age pensions limited to wage-earners could be considered satisfactory in Canada to-day. Consequently the question of getting contributions from persons other than wage-earners is at once posed. It seems quite unlikely that it would ever be practicable to establish a scheme of old age pensions by itself, for it is not until the age of 45 or 50 that most people think much about old age. In the 20's and 30's, old age looks a long way off. Youth always expects to be in a state of competence when old age arrives. Consequently it would seem that the resistance to establishing a properly constructed scheme of old age pensions by itself must be so great as to be hardly practicable politically. It would seem this would not be so for health insurance, for health insurance makes a strong appeal to persons of all ages. Apart from all other reasons for extending health insurance to rural as well as urban areas, to wage-earners and to non-wage-earners, the

establishment of a basis for the collection of contributions from the individuals insured for health insurance, this is exactly the desideratum for a scheme of contributory old age pensions. Then this seems to place health insurance in the position of priority at the present time. It is relevant to note in this connection that Sir William Beveridge's plan for social security is based on the three assumptions: (1) children's allowances, (2) comprehensive health and rehabilitation services, and (3) maintenance of employment. This confirms the place of priority of health insurance among the social insurances.

We may now consider with some profit the problem of getting health insurance into operation, for it seems to be supposed that if the proposed bill were enacted at this session we might almost forthwith expect health insurance to come into operation. The more we know concerning what is involved, the more effectively shall we face the issues; and it is as well that we should face the issues effectively now if we intend to have health insurance within any reasonable future. I have already given some idea of the time it took to get the very much simpler and smaller undertaking of Unemployment Insurance into operation, a plan for which nearly all of the patterns were available in advance and well-understood.

Health insurance will apply to the whole or practically the whole population, although it will probably come into operation only in one province at a time. From the point of view of the numbers insured, some of the administrative problems will be multiplied 4 or 5 times as compared with unemployment insurance, but that does not in any sense sum up what is really involved. Health insurance will affect all of the people in extremely intimate ways, and it will affect the professions and hospitals concerned in supplying benefit in equally, if not more, intimate ways. Consequently its application must be worked out with deft hands. The problem of collecting contributions from wage-earners will be substantially the same as under unemployment insurance, but as to numbers will be greater by perhaps 50 per cent. That technique is well-established. For persons other than wage-earners, the whole contribution technique has to be worked out *de novo*, for it does not appear to be worked out in any country. Nevertheless it must be worked out on the basis indicated in the draft, or on some basis which will attain the same objectives, not only as a basis for health insurance, but for other plans of insurance if we are to have them. It seems to be that health insurance is the parting of the ways so far as that broad issue is concerned. Unless it is worked out for health insurance, it will not be practicable to extend the social insurance method to old age pensions, disability, mothers' allowances—unless limited to those wage-earners under unemployment insurance—a rather crippling limitation at best.

Health insurance benefits will be provided under five heads:—

- (1) Medical, surgical and obstetrical benefit;
- (2) Dental benefit;
- (3) Pharmaceutical benefit;
- (4) Hospital benefit;
- (5) Nursing benefit.

Under each head the Health Insurance Commission in each province will have to make arrangements with hospitals and with each of the four professions for the supply of benefits. These arrangements will have to be confirmed by regulations having the force of law. The working out of these arrangements and the drafting of the necessary regulations will dwarf into complete insignificance the work involved in the preparation and drafting of the proposed draft for a health bill which the minister presented to the committee on the 16th instant. In Britain they have had health insurance for the past thirty years

limited, however, to medical and pharmaceutical benefits. The regulations for these benefits alone cover over 100 pages, $9\frac{1}{2}$ x 6, 10-point type or less, in a book recently published. I think it is clear that they cannot be reduced very much because in Northern Ireland they have their regulations and they run to about seventy-five pages. These regulations will probably be very helpful as respects the benefits covered, but our requirements will go far beyond those benefits. In addition, there is the problem of what may be called the business administration of health insurance, which has to be worked out in all detail before the scheme can be brought into operation.

It has been the intention all along that, as soon as practicable, committees of dominion professional associations and of hospitals, in association with officers of the Department of Pensions and National Health, should work out rules and regulations and the administrative organization and procedure to be passed on to the provinces for their general guidance and adaptation. This should reduce the work falling on the provinces and expedite the bringing into operation of health insurance.

I have already pointed out that for unemployment insurance the problems of administration developed, as it were, on the instalment plan. There were large opportunities for developing technique and procedures after the scheme came into operation, and that is still going on. For health insurance the whole scheme must go into operation as soon as contributions begin to be collected, or very soon thereafter. This is sufficient to show how completely and fully the whole scheme of operation must be worked out and understood by all concerned, before operations can begin at all. All of the rules, regulations and procedure must be worked out well in advance so that all concerned may know how the new arrangements are to work. A great deal of instruction will be necessary. In view of this perhaps it is unnecessary to warn of the dangers of attempting to put into operation at the same time any other kind of social insurance. This, however, would not necessarily apply where it was merely a question of collecting contributions for another kind of insurance along with the health insurance contribution, the contributions to be handed over to another administrative authority. That would apply to contributory old age pensions, money handed over to the dominion. There again until health insurance is in operation in the provinces it would hardly be practicable to begin the collection of contributory old age pension funds.

In indicating the magnitude of the problems ahead in establishing health insurance, it is not with the object of suggesting that they are too great to be faced but rather to suggest that unless they are faced with unremitting resolution and will by all concerned, it is scarcely possible that health insurance will become established at all. We certainly need not expect that we will lapse into health insurance once a dominion passes an act along the lines of the proposed bill.

Concerning the proposed draft for the bill, the minister and Dr. Heagerty have explained its provisions in general terms, and an explanatory memorandum has been distributed; consequently it hardly appears necessary that I should take up any of your time at this stage in going over ground already covered. The only way to get a good understanding of legislation is by reading it. Coming from the deft hand of Mr. Gunn, the draft is a monumental work in clarity. I am sure you will find it pleasant reading. There is one point of importance in considering a measure of this sort and it is that from practically every point of departure there are alternative roads. One may take the road which at that particular point offers the fairest prospect, but it may not be the best road to follow. It is only by considering the whole operation, the scheme and all its aspects that the road to be travelled can be settled upon. And, as already indicated, in doing this we should probably have regard for the other scheme of social insurance

which may follow. This is the alternative to mass production of social insurance schemes.

At this point, with your permission, Mr. Chairman, I should like to illustrate what I have in mind by a little story—off the record, if I may please.

The CHAIRMAN: Yes. Go ahead.

(The witness proceeded off the record).

The WITNESS: At the meeting on Friday a member raised some questions of an actuarial nature. The fact is that there are no actuarial issues involved in health insurance. In fact, actuarial issues are not involved in most kinds of insurance, they are statistical issues alone. Certainly actuarial issues arise with reference to long-term contracts of insurance—life, sickness, disability, and pension funds. There is one thing of importance, however, and that is we seek stability of finance. On the average, the cost of health insurance per capita should be fairly stable. Consequently, a uniform annual contribution per capita will give stability of finance, and this is important. That is what is proposed in the draft bill.

Thank you, Mr. Chairman and gentlemen.

The CHAIRMAN: Are there any questions?

Mrs. CASSELMAN: Mr. Chairman, there was mention made of the report of the National Resources Planning Board. I wonder if it would be worthwhile obtaining this, or if it could be obtained.

Hon. Mr. MACKENZIE: I tabled that at the last meeting.

By Mr. Wood:

Q. There is one matter which I should like to ask about, Mr. Watson. You mentioned the basis of collecting contributions from rural residents for the various social security schemes. Has consideration been given to utilizing the local municipalities for that? Of course, in the rural municipalities the residents remain fairly constant, but I quite realize that there are certain transients even among those. It seems to me that the local municipalities are much nearer to the people than any other form of organization. In order to reduce the cost of administering, I was wondering if it would not be worthy of consideration to give that aspect of the case some study?—A. That is a very proper question. As a matter of fact, there is a provision in the draft bill which will enable regulations to be made to the effect that, unless the person who is assessed pays up promptly, it may be handed over to a collector of the local municipality. That would generally apply, I think, however, only to those who had property within the municipality; but that can be worked out under the scheme as drafted.

The CHAIRMAN: Are there any other questions? Dr. Heagerty is present. If there are any questions for Dr. Heagerty, he will be glad to answer them.

Mr. WARREN: Do we get a copy of the address that Dr. Heagerty gave a little while ago?

The CHAIRMAN: Yes. It has been suggested to the chair by certain members of the committee that this week and next week we meet only once. It is stated that certain members have not had sufficient time to read and analyse the various reports and briefs that have been submitted, and that therefore they wish to have only one meeting this week and one next week. It is the committee's decision, not mine.

Mr. COTE: Very well.

The CHAIRMAN: We have a very large task before us. We cannot afford to lose many opportunities for meeting.

Mr. COTE: Do you need a motion for this purpose, Mr. Chairman?

The CHAIRMAN: Yes. I think that would expedite matters.

Mr. COTE: I would then move that we meet just once this week.

The CHAIRMAN: That is, that we do not meet again this week, but that we meet again next Tuesday.

Mr. COTE: Yes.

Mr. WOOD: What day?

The CHAIRMAN: Tuesday of next week; that is, to give members the opportunity of studying the documents.

Hon. Mr. MACKENZIE: I quite agree with the motion, but after these two weeks I think we shall have to sit much more frequently than we are sitting now if we are going to get any results out of the committee. There is a tremendous task before this committee, one of the biggest if not the biggest that has ever been before a committee of the house. I think that we shall have to obtain permission to sit while the house is sitting after the first two weeks. However, I think the request contained in the motion is a logical one.

The CHAIRMAN: I think the motion is intended to give the members the opportunity to study the documents. Then, with your permission, we shall meet next Tuesday.

There is one other point. Dr. Heagerty informs me that the Dominion Council of Health will meet in Ottawa on the 29th, 30th and 31st of this month—that is, Monday, Tuesday and Wednesday of next week. The deputy ministers of the provinces, I think, will be present and will be available to make a statement with regard to the measures in their respective provinces, if you so desire. Four of them have already stated that they will be available on Tuesday, if we wish to hear them. Their statements, I think, would be brief. It will give us some indication of what measures are now in force in their provinces. Is it agreed?

Some Hon. MEMBERS: Agreed.

Mr. McCANN: Have they already been invited to make any such statement? Have members of the Dominion Council of Health been invited to make any statement?

The CHAIRMAN: Yes.

Mr. McCANN: Is it the intention to receive a statement from them individually, or a statement reflecting the opinion of the Dominion Council of Health?

The CHAIRMAN: No. What I had in mind was individually, each in his own province, as to just what the province is doing.

Hon. Mr. MACKENZIE: They cannot speak on questions of government policy; it will be purely in regard to the actual legislation in force in the various provinces now.

Mr. MacINNIS: Who constitutes the National Council of Health?

The CHAIRMAN: It is the Dominion Council of Health.

Mr. MacINNIS: Then who constitutes the Dominion Council of Health?

The CHAIRMAN: Probably Dr. Heagerty could tell us that.

Dr. HEAGERTY: The Dominion Council of Health comprises the chief medical officer of each of the provinces, together with a representative of labour, of agriculture, of women's rural and women's urban organizations, with one skilled adviser. They sit at the direction of the minister at such times and places as he may direct. They sit under the chairmanship of the deputy minister. I thought that it might be advisable for them, while they were here in town, to appear as witnesses, if you considered it advisable.

The CHAIRMAN: Thank you.

Mr. MACINNIS: I am a little bit confused as to who "they" means. Does it mean the provincial deputy ministers or does it mean some other officers from the Dominion Council of Health?

Dr. HEAGERTY: Well, the chief medical officer of health may be a deputy minister. In some provinces there are departments of health with a deputy minister; in others there are boards of health with a chief medical officer—all, of course, under a minister of health.

By Mr. Gershaw:

Q. There is one question I should like to ask the witness while he is before us and it is in connection with the gathering of the contributions. In many districts of the west the people are scattered over a wide area. A great many of them are in rather poor circumstances. They find it very difficult, where there are four or five adults in the house, to pay these contributions. Is it assumed that the provincial government would pay for those who are unable to pay? I have reference particularly to small ranchers, farmers, hired help and transients who go from place to place. I think it would be a great burden for them to pay this amount. I wondered what consideration had been given to that.—A. Under the terms of the draft—which, after all, is really a general guide to the provinces—those issues can be worked out to meet the circumstances of each area. Did you have reference to the frequency of payment as well as their ability to pay?

Q. Yes.—A. So far as persons other than wage earners are concerned, it is proposed that they should pay only once a year. That would be much simpler. So far as their ability to pay is concerned, if it is ascertained that they are able to pay the full contribution, they will pay in full. If, according to the assessment basis used, it is ascertained that they ought not reasonably to be asked to pay more than three-quarters, they will pay three-quarters and the province will pay the rest. If it is determined that they ought reasonably only to be asked to pay one-half, they will pay one-half and the province will pay the rest; and so on. If it is determined that they cannot reasonably be asked to pay anything, the province pays the whole thing, and they will not appear in the insurance scheme as indigents. That is one advantage of the plan we have followed. The question of indigency does not arise.

By Mr. Donnelly:

Q. What would you say as to provinces which, on account of their financial position, are unable to pay by reason of the Sirois Report not being accepted? There are some provinces in that position?—A. Of course, those are issues that perhaps went beyond the purview of the advisory committee that prepared the draft. The whole scheme of the legislation is extraordinarily flexible; but, of course, flexibility will not take care of that situation.

Q. In the province of Saskatchewan at the present time we have much social legislation, and a great deal of it has had to be reduced because the province is not in a position to pay for it. Such provinces will be in the same position again when you take on this dominion scheme. They will not be in a position to pay when you do that.—A. Of course, any province can collect as much as it possibly can from persons who are insured. There again, of course, the difficulty would be encountered of the individuals not being able to pay. But the relative proportion would be, shall I say, scaled down to undertakings under the health insurance scheme to what they could pay for. That would be a possibility, although that is not indicated in the draft.

By Mr. MacInnis:

Q. I wonder if we could follow that a little further. All expenditure under this measure of insurance will not necessarily be new expenditure; that is, it

will not be a new burden to the whole of the people, because they are paying for medical services now. The extent to which the services they are getting now fall short of what they would get under the new act, would seem to me to be the only new financial burden involved. Would that not be so?—A. Yes. That is a very important point, and I do not know that that it has been perhaps fully understood up to this point of time. I think, broadly speaking, there is perhaps nearly enough money being spent by rich and poor to provide fairly satisfactory service for all concerned. Under the proposal the rich will not pay more than a certain maximum amount, which means that the income tax payer, by reason of health insurance, will be, shall I say, conditioned to pay a larger amount of income tax—and a substantial amount, too. That is to say, I believe something like $4\frac{1}{4}$ per cent is spent by persons in Canada of all income categories, year in and year out, on health services. Of course, that is not uniformly so for the individual. Sickness, hospitalization and that sort of thing does not fall on us uniformly; that is the main reason for having health insurance to iron things out. There is provision for a substantial grant, we hope, from the dominion; and the provinces will take care of the poorer people, to some extent at least. As I mentioned, the effect of putting the act into force will condition the income tax payer to paying larger taxes, which can be handed back to the health insurance fund as a grant.

By Mrs. Casselman:

Q. Has any survey been made as to insurance administered by private companies, and the rates paid? For instance, for health benefits, the mining companies and railway companies, etc., charge a certain amount to their employees.—A. I think Dr. Heagerty would know more about that than I do.

Dr. HEAGERTY: There are about two thousand industries in Canada which provide something more or less in the way of health benefits, and the costs vary to a very great extent. In some cases, a charge of one dollar a month is made to the employee, and you go all the way up then to the larger industries, such as the mining industry; and I might take Hollinger as an example, which makes provision for a form of health insurance for not only all of its employees but for the dependants as well. Their estimated cost is about \$20 a year to provide these benefits. The company itself provides only \$4 a year per capita, which is a comparatively small contribution. As to the amounts which are contributed by the insured persons, I would have to look them up as I am not familiar with them. I would have to look that up and obtain the information for you but, on the whole, the contributions and the cost of the scheme are comparable to the amount that we have estimated, that is, a cost of \$21.60 to provide full and complete benefits.

Mr. DONNELLY: Is that \$20 a month at Hollinger from everybody?

Dr. HEAGERTY: That is the amount of money it costs to provide the benefits.

Mr. DONNELLY: From everybody?

Dr. HEAGERTY: From everybody, for everybody.

Mr. DONNELLY: Those employed and those not employed?

Dr. HEAGERTY: Yes.

By Mr. Fulford:

Q. Mr. Watson, when you mentioned the figure of four and a half per cent I presume that only refers to personal illness, illness within the family; that does not include the taxes that one pays for various health services performed by the provinces? I refer particularly to the province of Ontario, the amount that is paid on tuberculosis clinics, on insane asylums and other health services, free vaccination and free toxoid clinics?—A. My understanding is that percent-

age is spent by the individuals concerned, they themselves and their families, on medical care, hospitalization, nursing and everything that goes with it. I believe both here and in the United States it is a fairly uniform percentage of the income.

By Mr. Wood:

Q. Would you consider that four and a half per cent of the national income?
—A. The income of the individual.

By Mr. Donnelly:

Q. Do they not collect five per cent in New Zealand and that does not cover major operations?—A. In New Zealand they have a whole scheme of social security, and that social security includes unemployment benefit, sickness benefit, widows' and orphans' benefit, invalidity benefit, miners' benefit, and universal old age pension, and in addition there is old age benefit in operation five years younger, but that is subject to means tests, and there is a general blanket clause that empowers the commission to take care of any cases of distress. There is a tax of 5 per cent on all income everywhere of any kind, and in addition there is a poll tax. They call it a registration fee but it is a poll tax of £1 on men 20 years and over and of five shillings on all other persons over the age of 16 years. I think I read this recently somewhere that the total cost was something like 8 per cent. I think the poll tax amounts to something like 1 per cent of income.

By Mrs. Casselman:

Q. Is that an annual poll tax?—A. Annually, what they call a registration fee.

Mr. CLAXTON: Following the reference that has just been made to New Zealand I wonder if it would not be a good thing at some stage of the deliberation of this committee to see if we could not get the Hon. Walter Nash up here. He has already spoken to the Reconstruction committee on the social security setup in New Zealand. No doubt you have considered that, Mr. Chairman.

The CHAIRMAN: We have.

Mr. CLAXTON: I hope it will be favourably considered. What I rose for was to ask Dr. Heagerty a question arising out of his statement, which I think is in accord with the experience of some of the rest of us, that companies like Hollinger can render pretty extensive health services to families at a cost of about \$20 per year per wage earner. That does not come near four and a half per cent of the annual income of the wage earner, and I wondered how that difference could be explained. There must be an explanation for it.

Dr. HEAGERTY: I do not know that I can give you an explanation of that, but our plan differs considerably from the Hollinger plan in as much as there is no charge made for children. It is the intention to distribute children among all of the contributors. That brings our cost up to \$26. Twenty-six dollars are necessary to provide for the children and to provide for the cost of administration. That will give \$21.60 per head for the provision of all other benefits that have been mentioned. I do not know that Hollinger does give benefits to the extent that we intend to give. I do not know if it is just as complete.

You have, for example, Associated Medical Services. The charge for Associated Medical Services is \$2 a head for a single person. There is a slight reduction for a wife and for a child. They, of course, provide a restricted service. They require the individual who is to be insured to fill out a form which would indicate that he is in good health and does not anticipate an operation. Moreover, the benefits are somewhat limited. Drugs are not provided,

and there are some other limitations. For example, if an individual has been insured and has had two, or perhaps more, operations then that individual is dropped from the list. No scheme that has been put in, or that has been contemplated, in Canada is as comprehensive as that which we envisualize. It is our intention to give full and complete and free service to everybody, to the indigent to the same extent as the contributor. You can see how that might have a tendency to increase costs. There are no indigents in the Hollinger or Associated Medical Services plans. Everyone pays and they are very closely governed and restricted. There will be no control of that nature and no restriction imposed upon insured persons in Canada. They will get everything that is available in the way of medical service that is known to medical science to-day; so you cannot provide that for nothing. You have got to pay for what you get in this world.

The objective of insurance is to provide a sufficient amount of money for the payment of all medical service distributed in such a way that it will not be a burden upon any one particular individual. That really is the object of insurance.

We think our estimate of cost is a very accurate one. As I pointed out—I have the figures with me here—a few days ago our estimates are identical with the present cost of medical care in the United States. The committee on the cost of medical care some years ago made an estimate of cost. They spent five years and made a very thorough and complete study. They estimated their cost at \$23.08. They took in all classes in the community. The estimate of cost in 1935 made by the Bureau of Statistics was \$23. It might have been 1 cent or 2 cents over. So that we feel quite certain that our estimate of cost is a safe and sound one.

While on this subject of cost I might point out that when British Columbia drew up its health insurance plan—in fact, passed a bill—in 1936 it was estimated that it would be possible to provide health insurance for \$12.50 with all of the benefits that we visualize with the exception of dentistry. You must remember that none of these plans that we have under consideration, Associated Medical Services or these various companies, consider dentistry.

Mr. ADAMSON: Hollinger does.

Dr. HEAGERTY: Perhaps they have recently put in dentistry, but that will increase their cost materially. The estimate of cost was \$12.50 for full benefits and \$6.25 for indigents. It was proposed to put in a special system of estimating for indigents which we think is quite erroneous. We think that indigents should bear the same estimate as others.

In the province of Alberta, which passed a health insurance act in 1935, the estimate of the cost was \$14.50. We consider that is too low; we consider it is far too low. It is not possible to provide full and complete benefits, exclusive of dentistry, under \$18. We figure that dentistry—and you will remember it is confined to children chiefly under 16 years of age—we hope we will be able to give it to children under 16 years of age—will cost \$3.60. The estimate of cost of dentistry for all of the people of Canada is somewhere between \$7 and \$10. We cannot get it accurately, but we think \$10 is the figure, and \$3.60 is a fair estimate of the cost of a semi-annual examination of the teeth of all children under 16 years of age, remedial dentistry that is necessary, and treatment of the teeth of indigents. So that in so far as cost is concerned we certainly are not high. There is always some danger we may be low but we just do not think so.

Dr. DONNELLY: Dr. Heagerty, we have eight municipalities in the province of Saskatchewan that have complete medical coverage and have been operating in that way for eight or ten years. Have you any idea what the cost is to them?

Dr. HEAGERTY: Yes, there is, of course, in the western provinces a system of providing medical care in the rural areas.

Mr. DONNELLY: There are eight municipalities that give complete hospitalization.

Dr. HEAGERTY: They do. If I might be permitted to lead up to that, just for the information of the members, in the province of Saskatchewan you have mentioned there is what is known as the Municipal Doctors' Scheme and the Union Hospital Scheme. The people are authorized to tax themselves to provide a doctor on a salary and also to provide hospitals for themselves in the community. I think they provide both their hospitalization and their doctor for something less than \$10, I believe \$7.50. Now, in considering this whole question of cost we have to take into consideration the fact that we will not be able to provide, certainly at the outset, in the rural areas full and complete service. We will have to put in the type of service that you have mentioned. Those costs are limited. They bear no relation whatsoever to the full and complete service we visualize. It must be remembered what we have in mind is not simply giving a doctor or a nurse; what we have in mind is the integration of public health and the building up of the people to create a healthy people. You cannot do that by a limited service.

I have had several talks with Dr. Davidson of the province of Saskatchewan, and he is extremely interested in this entire plan and he told me—this, of course, is quite unofficial as he has not authority to speak for his government—that the feeling of the people was that within a year after the dominion government has passed a health insurance plan that it would be implemented in the province of Saskatchewan. Where the money would come from I do not know, and I suppose that he does not know. It is possible for a time we will have to put in modified services in the rural areas and that may have a tendency to bring the whole cost down.

May I, sir, if I am not taking too much time say while I am on this question of cost that though many figures have been mentioned we cannot estimate the sum total of cost until we have sat down with the provinces and ascertained what they intend to do and what they can do. We have figures but we do not know what those figures mean. Our chief objective in ascertaining what a full and complete medical service would cost in Canada was to try and determine what would be a fair contribution on the part of the dominion. We know that in England that the present contribution is one-sixth of the cost of the benefits. We figured it here that about one-sixth would amount to \$3.60, one-sixth of \$21.60, but Sir William Beveridge has a great deal more courage than we have here. He estimates the full and complete cost of medical benefits, rehabilitation, and public health, all one if you will, at £170,000,000, and he provides that the British exchequer should contribute £130,000,000. That is more than three-quarters of the cost. The scheme that they envision there is pretty much the same as our own, that is, full and complete benefits for everybody. The planning commission of the British Medical Association would like to split up the whole of England into miniature clinics. There are some in this country who believe that is the ideal system, and I am fully in agreement with them and I think eventually we will move along those lines, but it is their intention to establish in the urban areas as soon as possible, although this is not final, miniature Mayo clinics, if I may call them that. Your group of doctors who will receive a patient, an insured person, will give him everything that is available in the way of diagnosis and treatment. We are moving along that line and we feel that in view of what we have in mind, what we have laid down, that our estimates of the cost are not great; but in the rural areas they will be less.

Mr. McCANN: That is getting away from the general idea of making the general practitioner the unit. He is going to be the servant of the other fellow.

Dr. HEAGERTY: I might elaborate upon that to some extent. Perhaps I have been too brief. It is not the intention that the general practitioner shall be pushed out of existence. There will be, as there always has been, the general practitioner outside of the clinics, but the insured person will be directed to the clinic by the practitioner outside rather than selecting the specialist here, the surgeon there, and the hospital at another point. It is felt it will be possible at a lower cost to obtain all the necessary specialist services at one particular point; but it is not the intention to push aside the general practitioner at all. He will occupy the same position that he does at the present time.

Mr. McCANN: I just want to add a word with reference to what has been discussed relative to cost. I do not think that we should attempt to compare too strictly or too much what the cost of such a scheme as we are studying would be relative to the costs of some of those private organizations. For instance, in my judgment, what the scheme costs in the Hollinger mine and what this scheme will cost are not fairly comparable, because they are on an entirely different foundation. We are starting off with one scheme; the Hollinger scheme did not come into effect when they started medical services in the community. It was taken over, and the service there now is being carried on in fine institutions which have been paid for by the shareholders of that organization. And then, in addition to that, they have no indigents at all. Every patient in their institutions, their hospitals, would be a paying patient. All the costs of these splendidly equipped institutions have been entirely written off and paid for. The cost with reference to all the health insurance schemes throughout the different provinces will take into account the fact that the costs of hospitals and clinics which are going to be used in the scheme will have to be written off or depreciated from year to year, and necessarily the costs will be higher in the provinces than they will be under any private scheme such as the Hollinger scheme.

Now, in order that I shall not have to rise again, Mr. Chairman, I want to revert for a moment to the question of calling some of the doctors, the deputy ministers of health, who will be here at the Dominion Medical Council next week. It all depends upon what information you want from them. They will probably not feel that they are in a position to speak for their governments with reference to policy or what position their provincial governments might adopt with reference to acceptance or rejection of this scheme. However, I think we should know something of the services that are being carried on in the different provinces and I would suggest to you that in view of the great distances from which these men come that it might be advisable, say on Tuesday, to have a meeting and probably call a meeting on Wednesday, although we have decided to have only one meeting next week, and that we hear from Dr. Amyot of British Columbia, Dr. Davidson and Dr. Bow—

The CHAIRMAN: Dr. Davidson will not be present.

Mr. McCANN: —from Nova Scotia and New Brunswick. As far as Ontario and Quebec are concerned the deputy ministers and the ministers of health in those provinces can be called here at any time, and probably if we call them at a later date we may receive more information from them than we could at this particular time. I merely throw that out as a suggestion in order to facilitate the work and to take advantage of their presence here in Ottawa at that time.

Now, there is another little matter that I want to speak about, and that is the matter of having only one meeting this week. I think that is something we all appreciate because there has been such a mass of material presented that it is absolutely impossible to digest it intelligently without considerable study, and I for my part would like to ask some questions of Mr. Watson

and Dr. Heagerty, but I have not really had the opportunity to study the very splendid presentations which they have made. I might very easily just from memory have asked some questions, but I might have got myself tangled up and not asked the intelligent type of question which I should like to ask.

Report No. 2 of the Social Security committee has just come to our hands this morning and we have not had an opportunity of reading or digesting the remarks of Dr. Heagerty, so I think we will be in a better position next week or probably the week after to ask questions on their statements. There is every reason why we should make haste, but probably making haste slowly is the best policy in the long run, because unless one lays a foundation on a proper basis with respect to what this whole problem is about, then one only becomes an automaton in this committee and one's services will not be of very much benefit.

The CHAIRMAN: Dr. Heagerty and Mr. Watson will be available later for questioning.

Mr. FAIR: Mr. Chairman, before passing on there is one item that I should like to refer to, and that is that the rural areas will be limited to a more restricted service to begin with. I would wish to point out we have approximately one-third of our population in the rural areas. Because they are in rural areas a number of these people are without medical services and have been for quite a number of years, that is, sufficient or adequate medical services; and if any way could be found to take care of these people to just as great an extent as it is in the urban districts I should like to see it done if at all possible.

I should like to point out also that these people will have to pay directly or indirectly for those in the urban areas.

The CHAIRMAN: That could be discussed in detail when we discuss the bill.

Mr. WOOD: There is another matter I should like to refer to, and that is what Dr. Heagerty said last week in connection with the submission put in by him. He made the statement that Agriculture or the Federation of Agriculture was very keen on a national scheme and that Agriculture wants the major part in the administration of that. Would you enlarge on that just briefly, why they want the larger part in the administration? How could they expect that?

Dr. HEAGERTY: I was approached by Mr. Hannam, the president, and Mr. Haskin, the secretary, of the Canadian Federation of Agriculture. They presented to me a brief which had been drawn up for them, not by Agriculture, but on their behalf. I read the brief with them and in reading the section dealing with administration I found there a statement to the effect that it was felt that the lay persons—perhaps I should say lay persons rather than Agriculture—should play a greater part in the administration than professional people. I shall bring you a copy of it and let you see it. I discussed that with them and I told them that that was inequitable. I told them I thought there should be equal representation on the part of each of those concerned, that it did not seem quite fair to have one person or any group of persons having greater control than any of the others; but there is no doubt that that is the idea of Agriculture, that the professions should be placed in a subsidiary position in regard to administration, if I have read through the brief correctly, but, of course, I stand to be corrected on that.

The CHAIRMAN: We shall adjourn until Tuesday, April 6. The Committee adjourned at 1 p.m. to meet again on Tuesday, April 6, 1943, at 11 a.m.

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Canada Social Security Committee 1943

SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 4

TUESDAY, MARCH 30, 1943

WITNESSES:

Dr. Jean Grégoire, Deputy Minister of Health for Quebec.
Dr. F. W. Jackson, Deputy Minister of Health for Manitoba.
Dr. P. S. Campbell, Deputy Minister of Health for Nova Scotia.
Dr. B. T. McGhie, Deputy Minister of Health for Ontario.
Dr. G. F. Amyot, Deputy Minister of Health for British Columbia.
Dr. R. O. Davison, Deputy Minister of Health for Saskatchewan.
Dr. J. J. Heagerty, Director of Public Health Services, Department
of Pensions & National Health, Ottawa.
Dr. C. W. MacMillan, Deputy Minister of Health for New Brunswick.
Dr. B. C. Keeping, Deputy Minister of Health, Prince Edward Island.
Mr. A. D. Watson, Chief Actuary, Department of Insurance, Ottawa.

OTTAWA
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PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

TUESDAY, March 30th, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Blanchette, Bourget, Breithaupt, Casselman (*Mrs.*), Claxton, Cleaver, Côté, Diefenbaker, Donnelly, Fulford, Gregory, Hurtubise, Kinley, Lalonde, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, McIlraith, Mayhew, Veniot, Warren, Wood and Wright.—29.

A statement respecting the Hollinger Medical Plan was submitted by Dr. J. J. Heagerty, and was ordered printed as Appendix "A" to this day's evidence.

At the request of the Chairman Dr. Heagerty introduced Dr. B. T. McGhie, Deputy Minister of Health and Hospitals, Ontario, who in turn introduced Dr. F. W. Jackson, Deputy Minister of Health and Public Welfare, Manitoba. Dr. Jackson made a statement on behalf of himself and the other Deputy Ministers of Health present, viz:—Dr. P. S. Campbell, Nova Scotia; Dr. B. T. McGhie, Ontario; Dr. M. R. Bow, Alberta; Dr. G. F. Amyot, British Columbia; and Dr. R. O. Davison, Saskatchewan; Dr. C. W. MacMillan, New Brunswick; Dr. B. C. Keeping, Prince Edward Island.

Mr. J. A. Blanchette, the Vice-Chairman, presided while Dr. Jean Gregoire, Deputy Minister of Health, Quebec, made a presentation in French.

Hon. Mr. Macmillan resumed the Chair.

Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, was recalled and further examined.

Mr. A. D. Watson, Chief Actuary, Department of Insurance, was recalled and further examined.

The above-mentioned Deputy Ministers of Health were questioned.

The Chairman thanked the witnesses for attending the Committee and expressing their views. Dr. McGhie, on behalf of the Deputy Ministers thanked the Committee for the privilege of being present, and pledged their cooperation.

The Committee adjourned at 1.05 p.m. to meet again at 11.00 o'clock a.m., Tuesday, April 6th.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS

March 30, 1943.

The Special Committee on Special Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: I have a statement submitted by Dr. Heagerty taken from the Canadian Doctor with reference to the progress of the Hollinger medical plan. With your permission, I shall put that on the record. Is that agreed?

Some Hon. MEMBERS: Yes.

(See appendix A).

The CHAIRMAN: This morning our first witness, who will be introduced by Dr. Heagerty, is Dr. B. T. McGhie, Deputy Minister of Health and Hospitals for Ontario.

Dr. HEAGERTY: The Dominion Council of Health is meeting at Ottawa at the present time; and the deputy ministers of health, whom you see before you lined up against the wall, thought they would like to take the opportunity of coming before you and presenting their views in regard to public health and health insurance. It is not the intention of each one of them to appear before you and express his views. It is thought that Dr. Jackson might act as spokesman and give you the substance of their views in English, and then Dr. Jean Grégoire, who is Deputy Minister of Health of Quebec, will translate that for you. I should have mentioned that Dr. Jackson is Deputy Minister of Health and Welfare of Manitoba. I am going to ask Dr. McGhie if he will introduce Dr. Jackson.

Dr. MCGHIE: Mr. Chairman, Dr. Heagerty has said so much better than I could just what I intended to say to you that I have a very simple task to perform. In our conference here as deputy ministers of health of the nine provinces, we have given some study to the matter that is before you, and decided that we could best serve your committee by asking two of our members to present the results of our deliberations. Dr. Jackson, Deputy Minister of Health from Manitoba, will, with your permission, speak to you; then Dr. Jean Gregoire, Deputy Minister of Health for the province of Quebec will also cover the same material.

The CHAIRMAN: Thank you, Dr. McGhie. I should assure the deputy ministers that the lining up against the wall does not imply punishment. I will now call upon Dr. Jackson.

Dr. F. W. JACKSON, Deputy Minister of Health for Manitoba, called.

The WITNESS: The deputy ministers of health, the provincial medical officers of health of the nine provinces of Canada and their scientific adviser, appreciate the privilege of meeting the parliamentary committee appointed to study measures of social security. On their behalf I wish to express thanks and to state that they are very pleased to assist the committee in any way. It is their feeling that their training and experience in preventive medicine and public health permits them to speak of matters relating to the integration of preventive medicine in plans for health insurance and to present essential information relating to public health in all its aspects. They are desirous of offering any information or opinion that may be requested by the committee.

To implement this, four members have been named to be at the service of your committee, in the interim between the meetings of our group as a whole. At this time, it is their desire to make reference to certain broad principles which should be incorporated in any provincial health insurance act, in order that preventive medicine and public health may take their proper place in any such plan.

Many public health problems are both national and provincial in scope and, therefore, require the resources and co-operation of the federal, provincial and local health agencies.

The principle of grants-in-aid for public health services, as indicated on page 10, schedule 1, section 3, of the draft health insurance bill, is strongly advocated. These grants are proposed to (1) aid the provinces with further development of their essential preventive measures, and (2) supplement provincial and local moneys required in the development of adequate local health services.

The benefits which are proposed in the draft bill before the committee appear to be quite comprehensive and the right of choice which is conferred upon the beneficiary respecting physicians and hospitals, we believe, is essential for the success of health insurance. In our opinion, however, the provision in so far as preventive services are concerned would appear to be too indefinite.

We beg to recommend in respect to administration:

1. That any proposed provincial act, as related to health insurance, be so drawn that the provincial government, after consultation with professional and other groups concerned, may administer such act through the provincial Department of Health or by a commission responsible to the legislature through the Ministry of Health.

2. In the event that the Act is administered through the provincial Department of Health, we beg to recommend that:

- (a) For the purpose of administration in carrying out the provisions of the Act and the regulations made thereunder, there shall be established within such department a division of health insurance.

- (b) There shall be appointed by the Minister of Health a director of the division of health insurance chosen from a panel nominated by the provincial division of the Canadian Medical Association—this particular provision may have to be altered to take care of the situation in Quebec where we understand there are three or four medical associations which have more or less equal standing in the province—who shall be a doctor of medicine, preferably with training in public health, regularly qualified, duly licensed and in good standing in the province and who has practised his profession for at least ten years. His duties shall be to administer and carry out the provisions of the Act and, subject to the approval of the Advisory Council hereinafter mentioned, to make recommendations to the minister in respect to the operation thereof.

- (c) There shall be created a provincial advisory council on health insurance consisting of the deputy minister or chief health officer, who will be chairman, two representatives of the provincial division of the Canadian Medical Association,—and the same qualification that I mentioned before in respect to Quebec applies here—and other persons comprising one representative each of the dental, nursing and pharmaceutical professions and of the faculties of medicine in the province and of hospitals, labour, industry and agriculture and of women's urban and rural organizations respectively; these to be appointed by the lieutenant-governor in council and shall hold office for a period of one, two or three years, respectively, as designated by the lieutenant-governor in council.

- (d) The provincial advisory council on health insurance shall meet regularly four times per year and may be called for special meetings at any time by the chairman or on the written request of any five members of the council.

3. In the event that any province should decide that health insurance be administered by a commission, we recommend that:—

(a) The commission shall consist of three members, one of whom shall be chairman. The chairman shall be a doctor of medicine, preferably with training in public health, regularly qualified, duly licensed and in good standing in the province and having practised his profession for at least ten years. The chairman and other members of the commission shall be appointed by the lieutenant-governor in council. The deputy minister of health or chief health officer of the province shall be a member of the commission *ex officio*.

(b) There shall be created a provincial advisory council on health insurance consisting of two representatives of the practising physicians in the province and such other persons comprising one representative each of the dental, nursing and pharmaceutical professions and of the faculties of medicine in the province and of hospitals, labour, industry and agriculture and of women's urban and rural organizations, respectively; these to be appointed by the lieutenant-governor in council and shall hold office for a period of one, two or three years, respectively, as designated by the lieutenant governor in council. The chairman of the commission and the deputy minister or chief health officer of the province shall be members *ex officio*.

(c) The council shall meet regularly four times per year and may be called for a special meeting at any time by the commission or on the written request of any five or more members of the council.

It is essential that any scheme of health insurance should provide for both preventive and curative services, and the general practitioner should extend to all those under his care the benefits of both, aided by such consultant and directional assistance as may be required. It is further appreciated that certain of the preventive services may be more effectively and economically carried out under provincial, district or municipal auspices.

In other words, certain of the services we feel may not come within the purview of the general practitioners and may have to be carried out by the provincial, district or municipal health agencies.

It is, therefore, urged that the provisions of any health insurance measure should require that the general practitioner assume responsibility for the following services and that provision be made for payment out of the health insurance fund to the general practitioner for rendering such services.

1. Pre-natal and post-natal supervision in keeping with the standards set by the Canadian Medical Association.

2. Medical supervision of infants and children under five years of age in keeping with the standards set up by the Canadian Medical Association; such supervision to include immunization against those communicable diseases which now are, or hereafter may be, designated by the association.

In conclusion we would emphasize that this statement, a copy of which we will present to the secretary when it has been duly signed by all of us, be considered as an interim communication from this group. We trust that the group, through its committee, may be privileged to present further information pertinent to the whole subject of health insurance as and where this standing committee may request it.

The CHAIRMAN: Are there any questions for Dr. Jackson?

By Hon. Mr. Mackenzie:

Q. I should like to ask Dr. Jackson one question, although he may not feel free to answer it. It might involve questions of provincial policy. I realize the situation quite well. Broadly speaking, there are two approaches to the question of national health insurance. One is a co-operative scheme with the provinces, not involving a constitutional amendment. The other is the suggestion that possibly 5 per cent, or a certain percentage of the national income might be set aside for these purposes and the whole system of health insurance

administered out of that by the dominion. From the point of view of your experience, if you can speak as deputy minister and not as a member of the government, which do you prefer? Have you given any thought to those two alternatives? Which do you prefer, speaking as a doctor and a deputy minister of public health?—A. That particular question was discussed by myself with members of our government, and they are of the opinion that the administration of health insurance should be provincial.

Q. Is that the opinion of any of the other deputy ministers who are here? —A. I believe I would be correct in saying that that is the opinion of all the deputy ministers. If any do not agree with it, let them hold up their hands.

The CHAIRMAN: There is one.

By Mr. Wright:

Q. Has your committee given any consideration to the proportion of the cost the provinces will be prepared to assume?—A. Mr. Chairman, answering the question, we did not give any consideration at all to the question of financing.

Q. Would not that come into consideration with regard to the 5 per cent of the national income? I think the Minister of Pensions and National Health might perhaps have been misleading on that fact.

Hon. Mr. MACKENZIE: No. That was taken for the sake of argument. It was not an established figure.

Mr. WRIGHT: I mean with regard to the cost of 5 per cent of the national income.

Hon. Mr. MACKENZIE: Of the income tax.

Mr. WRIGHT: Rather than leaving the cost on the provincial governments. The point I wanted to bring out was whether the provincial governments would consider a 5 per cent levy on the general income of the country as a whole rather than the provinces providing the cost from their revenues.

The WITNESS: I am sorry, Mr. Chairman, that I cannot give an intelligent answer to that question, because it has never been discussed that I know of in Manitoba.

Mr. WARREN: There was a hand put up over there, Mr. Chairman. Perhaps you did not notice it.

The CHAIRMAN: Yes, I noticed it. Are there any other questions?

By Mr. Diefenbaker:

Mr. CHAIRMAN: Has the scheme that has just been referred to by Dr. Jackson received the favourable consideration of the various medical societies across Canada; that is, the associations in the several provinces?—A. No, Mr. Chairman, it has not. That was prepared since we came here the day before yesterday.

The CHAIRMAN: Dr. Keeping, are you opposed to the provincial administration of health insurance?

Dr. KEEPING: No. I am in agreement with it.

The CHAIRMAN: Are there any other questions before Dr. Jackson leaves the witness stand? If not, will you introduce Dr. Grégoire?

The WITNESS: Dr. McGhie will.

Dr. MCGHIE: Dr. Grégoire, the Deputy Minister of Health for the province of Quebec, is the next witness.

The CHAIRMAN: I shall ask Mr. Blanchette, the vice-chairman, to take the chair while Dr. Grégoire gives his evidence.

The VICE-CHAIRMAN: Dr. Grégoire stated that he was informed last night of the submission he was to make this morning. He has prepared a stenographic

report of his remarks for this meeting and he is waiting for that report now. It will be along at any moment. In the meantime could I ask Dr. Grégoire of the general opinion as to provincial reaction to the points which have already been brought before the public in connection with these reports which have been submitted?

Dr. JEAN GRÉGOIRE, Deputy Minister of Health, Province of Quebec, *called*.

The WITNESS: I think the general opinion is fairly good. We are, of course, waiting to see what is coming on, that is all. I do not represent the opinion of my government here. Dr. Jackson said a moment ago on the question that was put to him by the hon. minister, Mr. Mackenzie, that his government was entirely of the opinion that he has expressed; but I do not know at all the opinion of my own government.

Mr. McCANN: With regard to your opinion, does it not represent what you, as deputy minister, will likely recommend to your government?

The WITNESS: Exactly.

The VICE-CHAIRMAN: Are there any further questions to be asked while Dr. Grégoire is waiting for the arrival of his brief.

Mr. MACMILLAN: I would like to call attention to the fact that the deputy ministers of other provinces are here and while Dr. Grégoire is waiting for his notes probably questions could be put to other deputy ministers. I am sure they would be glad to answer respecting their own provinces particularly.

Mrs. CASSELMAN: I wonder if the deputy minister for Alberta could tell us whether the Act as proposed now resembles to any extent the Act the Alberta government brought in and did not become law?

Dr. MCGHIE: Mr. Chairman, if I might speak for the deputy minister for Alberta who, unfortunately, is indisposed in his room at the hotel and was not able to come with us, although he is in accord with what has been submitted and has signed the report that Dr. Jackson submitted to you.

Mr. FULFORD: I would like to ask Dr. McGhie if he discussed this with his minister.

Dr. MCGHIE: I presume Mr. Fulford refers to the submission presented this morning. This was prepared yesterday and it represents, as in the case of the other deputy ministers here, my opinion as to the recommendations that might be made to the minister. Does that answer your question?

Mr. BLANCHETTE: We are happy to have with us the deputation of deputy ministers of the various provinces, and we extend especially a cordial welcome, we from Quebec, to the deputy minister of Health and Social Welfare of the Province of Quebec, Doctor Jean Grégoire. All the members from Quebec have long known Mr. Grégoire and are in a position to appreciate his long experience and his ability. I am sure that the evidence he will give here this afternoon will be of great interest to the whole committee.

The WITNESS: I thank you, Mr. Chairman, for your delicate attention to the deputy ministers of the provinces. I was asked at eleven o'clock last night to make a French translation of our proceeding of yesterday's meeting. I completed that translation this morning and I handed it over to a typist who will give me copies of same immediately. My colleagues, the deputy ministers of Health from the other provinces—and I am grateful to them for their gesture—insisted that the report of our proceedings be presented to this committee in the two official languages of the country.

By Mr. Cote:

Q. Must I understand that the province of Quebec subscribes without reservation to the views expressed by the other provinces, namely, that the responsibility for the administration of a Dominion-wide health insurance

scheme should be entrusted to each one of the provinces concerned?—A. That is really the stand I took as deputy minister and that is the recommendation I intend making to the minister of Health and Social Welfare, if this health insurance plan of the Dominion government is accepted by the province.

The WITNESS: Memorandum respecting health insurance:

The deputy ministers of health, the provincial medical officers of the nine provinces of Canada, as well as their technical adviser, are alive to the honour done them by the invitation to meet the Parliamentary committee charged with the study of social security measures. I wish to thank you on their behalf and say that they will be very happy to help the committee in every possible way. They are convinced that their training and experience in the field of preventive medicine and public health entitle them to discuss the questions concerning the part preventive medicine must play in every health insurance scheme, and present essential information bearing on all phases of public health. They wish to proffer any information or advice which the committee may seek. To these ends, four members have been assigned to keep at the disposal of your committee in the interval between the group's plenary sessions. They wish to refer at this point to certain general principles that should be embodied in every provincial health insurance act so that preventive medicine and public health may play the part expected of them in a system of this character.

Several public health problems are alike national and provincial in scope, and as such, they call for the resources and collaboration of federal, provincial and local health agencies.

The principle of grants for public health services set out at page 10, schedule I, section 3, of the health insurance plan, is strongly commended. The purpose of such grants is (1) to help the provinces to give a wider application to their essential preventive measures, and (2) to augment provincial and local appropriations needed to develop adequate local hygiene services.

The advantages proposed in the plan referred to the committee for study seem to be quite extensive, and the right conferred upon the beneficiary to choose the physician and the hospital he wishes is, we believe, essential to ensure the success of health insurance. In our opinion, however, the advantages foreseen in the matter of preventive services, appear too vague.

With respect to the application of the Act, we wish to make the following recommendations:

1. That every provincial health insurance bill be drafted in such manner that the provincial Government, after having consulted the professional groups and other interested parties, be able to apply such Act through the medium of the provincial department of health or by means of a commission responsible to the legislature through the medium of the department of Health.

2. Should the Act be applied through the medium of the provincial department of health, we wish to make the following recommendations:

- (a) For the purposes of the application of the provisions of the Act and its enforcement regulations, there shall be established within such department a division of health insurance.

- (b) The minister of Health will appoint a director of the division of Health Insurance who will be chosen from a group suggested by the provincial branch of the Canadian Medical Association. (This wording may have to be altered to take into account the situation in the Province of Quebec), who will be a physician preferably trained in matters of public health, fully qualified, duly authorized and in good standing in the province, and with at least ten years' experience in his profession. His duties will consist in applying and carrying out the provisions of the Act and, subject to the approval of the Advisory Council outlined below, in making recommendations to the Minister concerning the management of this Council.

(c) There will be set up a Provincial Health Insurance Advisory Council consisting of the deputy minister or the director of Health as chairman, two representatives of the provincial branch of the Canadian Medical Association (this wording may have to be altered to take into account the Province of Quebec) and others, including one representative from each of the following groups: dentists, nurses, druggists, provincial medical faculties, hospitals, labour, industry and agriculture, and women's organizations, both urban and rural; these representatives will be appointed by the Lieutenant-Governor in Council for a period of one, two or three years respectively, as specified by the Lieutenant-Governor in Council.

(d) The Provincial Health Insurance Advisory Council will meet regularly four times a year, and a special meeting may be called at any time by the chairman or on written application by five members of the Council.

3. Should the province decide that health insurance ought to be administered by a Commission, we recommend the following:

(a) The Commission will consist of three members, one of whom shall be the chairman. The chairman will be a physician preferably trained in matters of public health, fully qualified, duly authorized and in good standing in the province, and with at least ten years' experience in his profession. The chairman and other members of the Commission will be appointed by the Lieutenant-Governor in Council. The deputy minister or the provincial director of Health will be an "ex-officio" member of the Commission.

(b) There will be set up a Provincial Health Insurance Advisory Council consisting of two representatives of practising physicians in the province and of all other persons, including one representative for each of the following groups: dentists, nurses, druggists, provincial medical faculties, hospitals, labour, industry and agriculture, and women's organizations both urban and rural, respectively; these representatives will be appointed by the Lieutenant-Governor in Council. The chairman of the Commission and the deputy minister or the provincial director of Health will be "ex-officio" members.

(c) The Council will meet regularly four times a year, and a special meeting may be called at any time by the Commission or on written application by at least five members of the Council.

It is essential that every health insurance plan should make provision alike for preventive and curative services and that the general practitioner be able to give to all who are placed under his care the advantages of both such services, with the advisory and guiding help that may be required. It is realized that certain preventive services may be brought into play in a more effective and economical way under provincial, regional and municipal auspices.

Hence, it is recommended that any health insurance measure stipulate that the general practitioner must assume the responsibility for the following services, and that steps be taken to remunerate, out of the health insurance fund, the general practitioner who renders such services:—

1. Pre-natal and post-natal supervision in accordance with the standards set by the Canadian Medical Association.

2. Medical supervision of babies and children under five years, in accordance with the standards set by the Canadian Medical Association such supervision to include immunization against contagious diseases that have already been named by the Association or which may be named in the future.

In conclusion, we wish to insist on the fact that this statement, a copy of which we present to the Clerk, be taken as an interim communication and that the group, through the medium of its committee, have the option of presenting additional information bearing on health insurance considered as whole.

By Mr. Côté:

Q. Dr. Jackson inferred to the committee a moment ago that the Province of Quebec presented a peculiar aspect by reason of the large number of medical associations existing in that province. Would Dr. Grégoire be kind enough to tell us what are the medical associations that are recognized in our province? Personall, I know but one body, the Collège des Médecins et Chirurgiens de la province de Québec.—A. A medical society need not secure official recognition from the provincial authorities in order to function as such. Our principal medical society is l'Association des Médecins de langue française de l'Amérique du Nord. Amongst others, there are la Société Médicale de Montréal, la Société Médicale de Québec, la Société Médicale des Cantons de l'Est and numerous others. The Collège des Médecins et Chirurgiens of the province is an administrative body rather than a scientific society. It is intrusted with the application of medical law in the province.

Q. Will not such a large number of medical associations in the province be a serious obstacle to the establishment and smooth operation of a Health Insurance system in the province?—A. If ever a Health Insurance Act is passed, the Provincial Government, without doubt, will easily come to an understanding with the medical profession.

Mr. McCANN: Mr. Chairman, I have been following Dr. Grégoire as well as I could when he was speaking in French, and I should like him to tell the whole committee in English what he has already said in French. It is pretty well generally known that in the whole of the Dominion of Canada there are approximately 10,500 to 11,000 men in the medical profession. The Canadian Medical Association has in its membership about 6,700 of that group. There are not the proportion of the men in the profession of the province of Quebec who belong to that organization as in the other provinces. The question I want to ask Dr. Grégoire—I may say here that at a later date I have no doubt that Dr. Routley, speaking for the Canadian Medical Association, will put on the record the stand of the association as to the principle of health insurance—is it the opinion of organized medicine in the province of Quebec, through its different organizations, that they are favourable to the establishment of health insurance throughout the Dominion and in their province in particular?

The WITNESS: Mr. Chairman, that is a question very hard to answer.

I think Dr. Heagerty has had some answer from the medical associations in the province of Quebec, although I am not sure of it.

Dr. HEAGERTY: In 1932 the medical profession of the province of Quebec passed a resolution approving of health insurance. Does that answer the question?

Mr. McCANN: Yes, but which societies; there are a number of them. Which Quebec medical societies?

Dr. HEAGERTY: The Quebec Medical Society.

Mr. McCANN: What number of practising physicians does it represent there?

Dr. HEAGERTY: I could not answer that.

The WITNESS: About 200. Did you ever get a recommendation from the L'association des médecins de langue française de l'Amérique du Nord?

Dr. HEAGERTY: I wonder if I would be permitted to refer to section 45 of the Act, because it brings up the question of which is or which is not the responsible medical body in the province. Section 45 reads as follows:—

For the purposes of consultation concerning the terms of any regulations made or to be made under sections 28 to 32 inclusive hereof, and the making of the arrangements referred to in those sections with hospitals, or with the members of any profession, for supplying benefits

under this Act, the commission may recognize any committee which satisfies the commission that it is representative of hospitals, or of the members of any of the said professions, and authorized or constituted to promote and safeguard the interests of hospitals, or of the members of any of the said professions, as the case may be, concerning the operations of this Act

So that it is essential that it should be established in the province which is or which is not the official representative body before a committee is formed. The procedure is for the commission after appointment to sit down with committees of the medical profession, the dental profession, the nursing profession and other professions before entering into an arrangement for the provision of medical benefits. You can see therefore that it is most essential that there should be a full understanding as to which is the representative body.

In the province, it is pointed out by Dr. Grégoire, there are colleges of physicians and surgeons. They have certain and specific but limited duties. They are concerned with the registration and the licensing of doctors. In addition to that there are medical associations. Decision will have to be arrived at between these associations themselves as to which is the representative body. There must of necessity be constituted a representative body for the purpose of entering into an agreement with the commission for the provision of benefits. The situation in regard to dentists is different; there is only one authorized and legal body, that is the body with which the commission will deal, so that this question which has been brought up and discussed by Dr. McCann is an important one, but can be settled only by the provinces eventually.

Mr. McCANN: Of course you understand, doctor, that any licensing body is not a voluntary organization. It is a regulative body and is not in a position to speak for the profession at all comparable to a voluntary organization.

The DEPUTY CHAIRMAN: Dr. Grégoire, following up the question that Dr. McCann just asked a little while ago, would you be disposed to give us a general idea of what the impression is amongst the medical bodies in the province of Quebec in connection with this proposed health insurance?

The WITNESS: No, I would not, Mr. Chairman. I did not know that I was to be assigned to speak before this committee this morning. I shall not say anything that I am not able to prove. If I had all the recommendations that I have in my office in Quebec probably I could answer the question of Dr. McCann, but I am sorry I cannot do it now.

The Deputy CHAIRMAN: Are there any further questions? Thank you very much, Dr. Grégoire.

The Chairman, Mr. Macmillan, takes the chair.

The CHAIRMAN: I have a question for Dr. Jackson. Your recommendations included the appointment of a director of health within the provincial organization who shall have practised for ten years. Do you mean within the province concerned?

Dr. JACKSON: No, practised his profession anywhere in Canada, I would say, Mr. Chairman.

The CHAIRMAN: Dr. Campbell, the Deputy Minister of Nova Scotia, is present and I am sure we should like to hear from Dr. Campbell as representing the maritime provinces.

Would you care to say a word, Dr. Campbell?

Dr. CAMPBELL: Ladies and gentlemen, I think I have very little to say. I thank you for the courtesy extended to me in asking me to say a word or two, but my views are expressed in that brief which has already been submitted by Dr. Jackson and Dr. Grégoire. It is not in any sense of the word a government presentation, simply our views, and we think they are sound and that they should be incorporated in any health insurance plan.

The only other thing I can say now is this: it is a pleasure to be associated with my confreres, the officers of the other eight provinces, in preparing the statement. We had very little time in which to do it. We actually did not know we would have to make a presentation when we came to Ottawa, as we came here on other business. As the brief indicates, it is a preliminary brief. Dr. Jackson has said that a committee of council will be appointed, a committee representing the provincial officers, to give further information to this body if and when it is required.

The CHAIRMAN: Dr. Campbell, would you care to express an opinion with regard to the probable reaction to this measure in the maritime provinces, or the attitude taken?

Dr. CAMPBELL: No, sir, I just do not feel competent to express an opinion new because I might be doing the measure a wrong. I really do not know. There has not been up to the present a great demand; I would say that; and I suppose it is largely due to the present employment conditions. During the depression years there was some demand for a changed system and we all feel that a change is in the offing and that we should move slowly and see that we produce something very sound and which will solve the medical and public health problems in each of the provinces.

There are so many groups whose viewpoints are procured that it would be extremely hazardous to say we would give an opinion as to the percentage either in favour of a measure of this kind or opposed to it.

If there are any other questions that I am able to answer I shall be glad to do so.

The CHAIRMAN: Thank you, Dr. Campbell.

Mr. McGARRY: May I ask Dr. Campbell if he would be prepared to say that the brief which was presented this morning expresses in a general way the attitude of the provincial medical associations?

Dr. CAMPBELL: No, Mr. Chairman and Dr. McGarry, I would not say that; it expresses our views.

Mr. McGARRY: It does not reflect the expressed view or the opinion of the provincial medical associations?

Dr. CAMPBELL: No.

The CHAIRMAN: You would not care to pass an opinion?

Dr. CAMPBELL: We would not speak for the many different medical societies; that is our view. The views expressed are the views of the officers of health of the nine provinces.

Mr. VENIOT: Just a few moments ago you asked Dr. Campbell to give an expression of opinion concerning all the medical professions in the maritime provinces and what they thought about the question of health insurance. May I say that the Medical Association will appear before this committee in the person of Dr. Routley to present its brief and he will be able to give a reply to this particular question which you just asked concerning all the provinces of Canada with the exception of the province of Quebec. Dr. Routley will, I think, tell you, after making what we consider a survey of the entire medical profession outside of Quebec—approximately 90 per cent of the medical profession outside of the province of Quebec replied to the questionnaire which we sent, that they express an opinion favourable to the adoption of a measure of health insurance.

The CHAIRMAN: Thank you, Dr. Veniot. How wide was the distribution of the questionnaire?

Mr. VENIOT: The questionnaire was sent out to all the doctors who reside outside of the province of Quebec, and to those in the province of Quebec who

are members of the Canadian Medical Association, and I should say that the questionnaire went to 8,500 doctors.

MR. CLEAVER: Dr. McGhie, I take it that you and the other deputy ministers of health are primarily interested in preventive medicine. Would you care to express an opinion as to the adequacy of the provision in the proposed Act in that field?

DR. MCGHIE: I think that point has already been covered in the presentation made by Dr. Jackson with which we are all in full agreement. Your first statement that we are primarily interested in the prevention of disease is correct. I think it is already stated in the brief that we feel that going hand in hand with that is the activity of the practising physician and that he must, if this is to be successful, at least he should have a part in the program of prevention as well as in that of treatment or cure.

MR. CLEAVER: If your proposed suggestion should be accepted, doctor, that is, the suggestion contained in your brief, would the present proposed Act in your opinion be wholly adequate so far as prevention of disease is concerned?

DR. MCGHIE: That is our belief through the discussions that we have had in the last twenty-four hours.

MR. WRIGHT: I wish to ask a question of the Saskatchewan doctor with respect to the municipal doctor scheme which is already operating in the province of Saskatchewan. Has consideration been given to the incorporation of that in any proposed Act?

DR. DAVISON: Mr. Chairman, I asked Dr. Heagerty that question as we felt there should be some form of either the municipal doctor system or the district medical services in Saskatchewan, and I understood from him that there was provision to carry out a similar scheme.

THE CHAIRMAN: Will you comment on that, Dr. Heagerty?

DR. HEAGERTY: The first duty of the Commission is to make a study of all facilities of all of the provinces, and then having done that they are to sit down with the representatives of the provinces, as I indicated briefly a short while ago; and having ascertained their facilities and their problems they are then to set up an administration. The intention is to divide the province into public health and health insurance areas. Now, it is obvious, I think, it would not be possible for a commission to provide one type of administration on health insurance for an entire province. The commission will have to take into consideration the facilities and the problems that face them. It will not be possible in the rural areas to provide the same type of administration in all probability as in the cities. I think I mentioned at the last meeting that you have in the cities all facilities available for providing medical services, but you have not in the rural areas, and it will take a very long time to provide them. The municipal doctor system in Saskatchewan and the contract doctor system in Alberta meet the need and will continue to meet the need for some considerable time. The union hospital scheme of Saskatchewan and the municipal hospital scheme of Alberta will also be used. It must of necessity be left to the commission to study their problems and to administer to those problems as best they can. Perhaps Mr. Watson who is here pouring over the draft bill may be able to put his finger on the section in mind. Can you do that, Mr. Watson?

MR. MACINNIS: Mr. Chairman, I should like to ask if the proposals presented to the committee this morning by Dr. Jackson were the result of deliberations by medical men only or by medical men and laymen?

DR. JACKSON: By medical men only.

MR. MACINNIS: I thought as I listened to it that it was a representation of the union and the members have to keep in good standing if they want to get anywhere.

Hon. Mr. MACKENZIE: That is why you liked it?

The CHAIRMAN: That was the home touch.

Dr. JACKSON: In reference to the suggestion it was the voice of the union speaking, I should like to suggest the health officers are not the voice of the union of medical men in Canada. There might be some other gentlemen here who might express the voice of organized medicine in Canada better than the health officers. There is one other point. Dr. Heagerty said in reference to municipal doctors that they were now filling a need in certain areas in rural western Canada. I should like to qualify that and say that they are just providing some of the need required in respect to medical services, not all of it, just some of it.

Mr. FULFORD: Mr. Chairman, I should like to ask a general question somewhat along the lines of Mr. MacInnis' question and on the closed shop. There is no provision to be made to include on those health committees or commissions osteopaths, chiropractors and masseurs. After all, in a modern community they do form, in so far as the layman is concerned, an important group and perform a useful service. Speaking as a layman myself I cannot help but feel they perform a useful function.

The CHAIRMAN: Can you answer that, Dr. Heagerty, please?

Dr. HEAGERTY: Well, the Greeks have a word for it, we have two, we call it "auxiliary services." The doctor has the privilege of utilizing the services of the masseur, the osteopath and the chiropractor and any other service that he thinks his patient needs. That, I think, covers all these other questions.

Mr. FULFORD: I rose to my feet on this point. I hoped that if the medical profession became all powerful they would not outlaw the so-called drugless practitioner.

Hon. Mr. MACKENZIE: Would that not be a matter for the various provinces to decide, according to their own laws?

Dr. HEAGERTY: It depends upon the definition of general practitioner. We have used, I think, Mr. Watson, the name "general practitioner." I believe in one province, and that is in British Columbia, the chiropractor—and I hope I am right in this; perhaps Dr. Amyot will correct me if I am not—is a general practitioner or general medical practitioner. There is some misunderstanding in connection with that, because at the meeting of the General Medical Council of Canada it was stated by a representative of British Columbia that the osteopath, the chiropractor or naturopath, one, either, or all, were entitled to the term "general practitioner" in British Columbia. If that is the case, then the insured person may not go direct to a chiropractor or osteopath, but will be obliged to go to a general practitioner.

Mr. CLEAVER: Do I take it from that answer, Dr. Heagerty, that a person who is ill will not be able to have the services of a chiropractor under this Act, until the general practitioner recommends that he requires those services?

Dr. HEAGERTY: That is what they will have in mind.

Mr. CLEAVER: That would appear to be highly dangerous.

Mr. WOOD: Dr. Heagerty, I should like you to enlarge upon your recommendation in regard to the scheme proposed for the rural sections, those sections in the Dominion of Canada which are somewhat adjacent to urban centres or more thickly populated sections. Would it be possible to give them the same services that you would give in the urban sections? For instance, if you happened to be located anywhere within twenty miles of the city, what is it about the service that they would not be able to get but which an urban centre would get?

Dr. HEAGERTY: In the urban centre you have every facility available and at hand.

Mr. WOOD: Such as X-ray, you mean?

Dr. HEAGERTY: No. I mean you have got right at hand your consultant, you have your specialist; you have your surgeon; you have your hospitals; you have your private room in the hospital, if necessary; you have your X-rays, as you say. All of these are available on the spot. You cannot take all of these to the rural areas immediately. It has been thought that it might be possible to be able to do it eventually by establishing clinics, as I mentioned at the last meeting. Eventually, I believe all of these services will be made available, but you cannot do it at once. A considerable amount of it will be in the nature of emergency services. You mentioned that many of the people will be in the neighbourhood of an urban area. You can bring those people in. But many of them are going to be very remote also from urban areas; I think Dr. Grégoire will tell you that along the north shore there are no doctors, and that nurses are carrying out the work. If I remember aright, at one meeting of the Dominion Council of Health, you told us, Dr. Grégoire—and you might verify this—that some of the nurses were capable of performing operations in those areas. Would you specify the nature of operation that some of them performed?

Dr. GRÉGOIRE: It was only in the case of emergency. We have practically two hundred nurses giving medical care in the far removed districts in the province of Quebec, on the north shore and the Gaspé peninsula. They are sometimes fifty miles from the nearest doctor. The nearest doctor usually goes to help the nurse, when she can get him. But it sometimes happens that a case of emergency will occur, and the nurse must take responsibility that she would not take if she were able to get a doctor.

The CHAIRMAN: Mr. Watson, have you the section that Mr. Wright asked for?

Mr. WATSON: Yes. If I might, Mr. Chairman, I should like to perhaps cover the matter from a little wider point of view than that particular section alone. If I might refer to section 3 of the Dominion Act—

The CHAIRMAN: Will you speak a little louder, please, Mr. Watson?

Mr. WATSON: I shall try. Section 3 of the Dominion Act—that is, the Act apart from the schedules—provides that grants may be made for certain particular purposes. In section 4 it provides that “the statutory provisions as respects health insurance shall be in such terms as to provide health insurance benefits of the standards, under the conditions and for the classes of persons, as set forth in ‘A draft for a Health Insurance Act’ in the second schedule to this Act, or substantially in the terms aforesaid.” Although there is a schedule attached, it is a sort of model Act for the provinces. It is really a suggestion to the provinces. They may pass an Act substantially in those terms, or an Act “in such terms having regard for all the circumstances, for the special conditions affecting the province as a whole, or any special areas in the province, may be accepted by the Governor in Council as a satisfactory practical measure of health insurance for the province.”

In the first instance, you will see that the dominion contemplates the widest possible flexibility in order to bring health insurance to each province in the most satisfactory manner for that province.

In the provincial Act, the provisions in regard to benefits fall under five general heads. It remains for the commission, or whatever administrative authority may be settled upon in the provincial Act for administration, to work out the rules and regulations for administering the several benefits. There is no difference in the five sections. The five sections provide for general provisions applicable to the province as a whole. There is no modification there. There is no suggestion that there should be any difference in the benefits for rural areas as distinguished from city areas; and so far as most of the provinces

are concerned, I do not think there is any doubt but that the rural areas adjoining the cities, villages and towns will get the same services, because they come into the hospitals where the facilities are.

There is a provision in section 33 on page 42 to which I wish to refer. As I mentioned before, the idea is that there shall be great flexibility to meet the needs of every area. In section 33 there is a provision which will enable the administrative authority in the province to exempt any difficult areas that would not be properly serviced by the general arrangement and provide the best services possible for those particular areas. It is not the intention that those special arrangements should apply generally to rural areas, but only to areas of special difficulty. I should say for the province of Ontario, practically all the rural areas would be handled on the same basis as a city, town and village area; but naturally there are some areas, like up at Georgian Bay and so on, where they probably could not be handled on that basis. But it is for the provincial authorities to settle upon which areas must be handled in a special fashion. The last subsection in section 33 provides, I think, a workable arrangement. It reads as follows:—

If, as respects any particular area, in the opinion of the Commission, it is not reasonably practicable to administer satisfactorily any one or more than one of the benefits of this Act under the general arrangements—The general arrangements are the arrangements that I have just mentioned.

—made for administration thereof, the Commission may by regulation made hereunder

(a) make other arrangements for the administration of benefits in that area; or

(b) put into operation such modification of the scheme of benefits of the Act as may be practicable for that area; or

(c) put into operation such alternative scheme of health insurance benefits or services and arrangements for administration thereof as may be deemed appropriate and in the best interests of persons in the area.

That is only to be done after a survey has been made of the whole province. The first part of section 33 reads:—

As soon as may be after benefits become available to qualified persons under this Act, and thereafter whenever it may seem desirable so to do, or at the direction of the Commission, the committee empowered thereunto in each region, shall, after making a complete survey of the conditions throughout the region, or such survey as may be directed by the Commission concerning the administration of the benefits of this Act, the availability of professional personnel, and the facilities for administering the said benefits, prepare a report for the Commission describing the conditions prevailing in particular areas throughout the region as respects the provisions of this Act and, where deemed necessary, containing therein a scheme or schemes for improving in practical ways the administration of the benefits aforesaid and for making those benefits as readily available as may reasonably be practicable to persons living in all parts of the region, and the report shall show in order of urgency, the several recommendations and the estimated cost thereof:—

With that report before them, the commission will naturally take into consideration all the evidence available, and so far as may be practicable I should suppose they would apply the general scheme of administration—except, I think I am safe in saying, in remote areas—uniformly or substantially uniformly. People in the rural areas in Ontario—for instance, in the rural areas around Ottawa—are accustomed to getting their medical services and

hospitalization just the same as the people in Ottawa are. They come into the city for our services. It is the intention, as far as the draft goes, that such practice should be continued. At all events, it is open to the provinces, when they come to work out their scheme, to have this put in, if they wish.

Mr. CLEAVER: As to those remote regions where well-rounded facilities are not available, is there any power under the Act whereby the cost to the patient under the Act should also be modified?

Mr. WATSON: That would be a matter to be worked out by the provinces.

Mr. CLEAVER: Is there power in the bill for the provinces to work that out?

Mr. WATSON: That is not suggested. There are many things in the draft that are not suggested, and that are left to be worked out. But there is this to be kept in mind. Whatever service was given in a remote area would be very expensive and would cost out of all proportion to the contributions made by the people in that area. Then again, to-day with modern facilities, even remote areas may get services by way of hospitalization—through the use of the 'plane, for example, to bring people in to hospitals. All these possibilities are open. It is not the intention that this draft should suggest any rigidity, but rather to leave it to the people on the spot to work out the best possible services they can, taking all considerations into account.

Mr. MAYHEW: Mr. Chairman, I realize that in Canada we have a good many industrial firms that are carrying on some plan of health insurance. I think they are varied. They have been more or less groping around to find the best solution. I think some one said the other day that there were about two thousand different companies with health insurance plans. I think there are between two hundred and three hundred different plans. At the same time, I was wondering if there was any means of recognizing the health insurance plans that had been worked out by company towns. There are several towns that are run entirely by the company, in which all the employees and their families are living by reason of their working in that industry. I was wondering if there is any way of recognizing their plan. I think some of the plans that are in effect are probably going to give to these families cheaper insurance than is mentioned in this present bill.

Dr. HEAGERTY: We have not made any provision to include them nor have we made provision to exempt them. I think I am right in saying—and Mr. Watson will correct me if I am not—that it is quite possible for the commission to make special provision. But we thought it was advisable to leave them out because, as has been indicated, there are two thousand different firms in Canada which provide fragmentary forms of health insurance. We are of the opinion that many firms might use the exemption to exclude themselves from health insurance simply in order to avoid the necessity of making contributions. We mentioned the Hollinger mine the other day as an example of one of the best types in existence in Canada. Under that plan, the Hollinger administration makes a contribution of one dollar four times a year, and that is all. It is the employees who furnish their own services, in conjunction with a group of doctors. It is an association for the provision of medical services. We propose—and I am repeating myself—to include ancillary contributions of the industry, the employer. If those firms are capable of excluding themselves from the operation of the Act, you can see where we will be left out in the cold. We gave a very great deal of thought and consideration to that whole question before we decided we would not make any special provision for them.

Mr. KINLEY: I take it, Mr. Chairman, that the committee before us this morning is not the Dominion Council of Health, but rather that part of it which constitutes the medical officers from the provinces. They are professional men, and we would expect them to deal with professional matters. But they are also executive officers of public health in their provinces. They have not dealt

at all with the financial set-up of social insurance in Canada. In this regard, there are provincial questions that might very well engage their consideration. For instance, in the Beveridge Report there are several outstanding points. One is co-ordination and centralization for the purpose of economy and efficiency. In Canada evidently, we are not going to have a dominion scheme of social insurance, but we are going to have enabling legislation which is directive and must be accepted by the provinces before it can go into effect. The thought comes to me—interested as I am in industry, as is my friend who just spoke—that industry does not object so much to the paying of premiums and the paying of dues, as they do object to the great increase of office work and duplication of work in the different schemes and in the different features of all these plans. It seems to me that if the deputy ministers of the provinces went home and considered the idea of whether or not they could co-ordinate their scheme of compensation, mothers' allowances and health insurance, and also perhaps make some recommendation to the dominion government with regard to taking on some features of our unemployment insurance, having mechanics that would centralize the whole thing under one control for the purpose of saving, creating economy and making less work, it would be of great advantage. Mr. Mayhew talked of people who are now in the business. In the Beveridge Report they sweep the field clean. They say, "We are in the days of revolution and in the days when we should do things in a big way for the benefit of the people." It seems to me that, in a field of this kind, we should not stop at anything that would make for efficiency or co-ordination of effort to do it in an effective way in the provinces. It seems to me that that feature of the Beveridge Report is a feature that the provinces throughout should take into consideration, having regard to the set-up which it seems will be recommended.

The CHAIRMAN: Have you a comment on that, Dr. Jackson?

Dr. JACKSON: Mr. Chairman, ladies and gentlemen: I am very glad that particular question has come up. As probably a good many of you know, in Manitoba the provincial government, in 1928, set up a department known as the Department of Health and Public Welfare, the ultimate idea being that all activities in respect to health and welfare would come under the direction of one minister of the crown. We have not got into the division of welfare all those things in provincial government which have to do with welfare, but these are gradually being put into the welfare section. I am sure, Mr. Chairman, you will be interested in knowing that we have had this very thing which the speaker has just discussed under consideration for two or three years. We have the province divided into districts in which there will be a central administration having to do with public health, hospitalization, welfare services and health insurance, if and when it comes, and if it is under the jurisdiction of the Department of Health. I quite agree, Mr. Chairman, that it is the height of fallacy, in my opinion—and I speak personally now, and not for the rest of the deputy ministers—to have duplication of administration, if it is possible to have the administration of all matters under one head. I can foresee possibilities that instead of a Ministry of Health and Public Welfare we may ultimately have in the provinces a Ministry of Social Security, if you like to call it that, and all of these things will come under that ministry and all of them will be administered under one central set-up. This will be decentralized by means of districts because, taking health insurance or the medical care problem as a whole, there is no way you can get out of the fact that hospitalization, dentistry, nursing and public health, all interlock; and they interlock to such an extent that I think it is highly undesirable to have a central administration for each or for any group of them. I think that should be under one definite administration; and the same applies to most welfare services. When we look back over the record of welfare work in Manitoba, we can look at our mothers' allowances, for instance, and we can see that 39 per cent of the money being expended for mothers' allowances at the present time is being

expended because the breadwinner is either dead or completely disabled, as a result of a condition which was preventable. How can you divorce that welfare from health? It cannot be done. If we are going to discuss the amount of money we require for social services, we have to increase the provision for health and medical care; and I say that in all honesty. I believe that the best and most economical way of doing this is by some unified administration of all these things.

Hon. Mr. MACKENZIE: Mr. Chairman, I quite agree with Dr. Jackson in regard to most of what he has said. Mr. Kinley who just preceded him mentioned the Beveridge Report which does advocate a measure of social security in Great Britain. But you will find that while he does advocate the setting up of a Ministry of Social Security, he does not put the health services of Great Britain under that ministry, but leaves it under the Ministry of Health of Great Britain. Conditions there are very different from what they are in Canada. That is a very salient factor.

Mr. KINLEY: What I had in mind was this. In Canada our conditions are different.

Hon. Mr. MACKENZIE: Quite.

Mr. KINLEY: We have provinces which have governments of their own. That feature of the Beveridge Report could very well be made the objective of the provinces, for their compensation, their mothers' allowances and their health insurance—all under one head and co-ordinated in that way. It may be that we should have a feature in our bill that will give the provinces the privilege of doing that. Coming from industry, I know they want to make the thing as simple in its mechanics as possible.

Hon. Mr. MACKENZIE: I quite agree with you.

The CHAIRMAN: Have you any comment, Mr. Watson?

Mr. MAYHEW: Mr. Chairman, I should like to say a word here. I rather think that one of the statements of Dr. Heagerty is a little bit unfair to industry. Industry is not trying to evade its responsibility in connection with this. Industry has been groping for a long time to try to find out a way to do it. What I spoke of particularly was the company town where there is a community. What is the difference between a company town and a municipality in any province? I just simply asked whether they would be recognized the same as a municipality might be recognized. I realize that from the standpoint of social security as well as old age pensions, industry is not in a position to handle it, because that entails a long period of work in that one company in order to be successful. But when it comes down to medical health, I think he will find on examination that there are industries in Canada to-day that are giving all of the people in that industry a greater benefit than is proposed by this Act. But to infer that industry is not willing to co-operate is, I think, grossly unfair; because they are willing to co-operate and have been seeking a way to do it.

Mr. McCANN: Mr. Chairman, there are two or three questions that I should like to ask the deputy ministers. The first one I wish to preface by a few remarks along this line. I think it is generally recognized that should health insurance come into effect, there will be a greater need for institutional care. I think that we can put that down as one of the results. More people will be hospitalized, more people will be taken into institutions and they will receive whatever medical care is to be given them in those institutions. It is also generally recognized that there is a great shortage of institutions in the country, in all the provinces, to provide that care. If we are going to look after people who are mentally ill,—and we have about 50,000 of them throughout Canada at the present time, and probably a great many more who are in private homes but who should be in institutions, if they want any chance for either

treatment or the protection of the rest of the community—we will need more institutions. That condition obtains with reference to general hospitals and it obtains with reference to institutions for the treatment of tuberculosis and cancer. Another way in which we are short there is that we have hardly any publicly-owned institutions in the whole country, for the treatment of people who are convalescent. It is generally recognized that such institutions can be set up and carried on on a per capita and per diem rate at an amount less than presently obtaining. Now, that being the case there would likely be a great program put forth throughout the country to bring the institutions up to capacity. Are the provinces going to be in a position or would they recommend the undertaking of the capital expenditure which would be necessary in that regard or do they look to the federal government to supply that capital expenditure as part of its social security program? That is a question which I think ought to receive—perhaps it has received—the very serious consideration of those who have to do with provincial administration. If it is going to be brought up to date with reference to institutional care why the expenditure will be enormous and the Public Health Act as presently drafted cannot be carried out unless that provision is made.

Now, the second question I want to ask has to do with the one that Mr. Mayhew has brought up and which I intended to bring up and that is with reference to the private organizations that are giving health services especially in industry. There need be no defence of what industry has done with reference to the medical care in those communities and industries. As a matter of fact there it should be—I voiced it on other occasions and do not hesitate to voice it at the present time—recognized that governments have been dilatory in connection with both provincial and federal services in giving the proper health facilities to the people of this country. Industries have been the pioneers and they have given health services throughout this country in the past quarter of a century or longer, which should have been the undertaking of government. That is my own view upon the matter and that is the view which is shared by a great number of people. The question is: What, in the judgment of the deputy ministers, is going to be the reaction of those different organizations with reference to being taken under any general scheme of health insurance in those provinces? That is another question which will take an awful lot of consideration. I may say that as far as the bill goes, the bill which is drafted, it does take very heroic action along that line when they undertake to take in a couple of thousand organizations in a country like this and put them under a scheme, and take them over practically from private ownership. That has been the opinion in so far as industry is concerned. What those industries have done for their employees is equal in importance and in benefit to having paid these people probably a greater rate of wages than they have paid them for years. That is one of the many benefits which industry has given to its employees, and to dislocate that whole arrangement, which is common to so many industries, I say takes heroic action upon the part of any government, and it is a question which will merit very serious consideration.

I should like to know too from the deputy ministers what the reaction is in their different provinces, what the reaction is of those in the agricultural communities with reference to coming under a scheme which has been suggested. I heard expressions of opinion when I was home over the week-end from some farmers and those interested in farm organizations to the effect that they thought the rate to be charged to people in the rural areas was entirely too high. Perhaps the deputy ministers would be in a position to give us some opinion upon these matters.

The CHAIRMAN: Dr. McGhie or Dr. Jackson, will you please comment?

Dr. MCGHIE: Mr. Chairman and Dr. McCann, in response to Dr. McCann's first question as to the need of expansion of institutions to care for the sick,

some four or five months ago this group of deputy ministers undertook a study of all the provinces with a view to determining the present situation as to overcrowding of hospitals, lack of sufficient beds for the mental hospitals and sanatoria, and I think we are extending the study now to the point where we can be in a position to bring to your committee eventually the requirements as we see them in all the provinces with respect to hospitals, whether it is for the physically sick, the mentally sick, the tuberculosis or old age. The matter of where the money is coming from to meet this need is a matter which perhaps the finance departments of governments, federal and provincial, are in a better position to say than this group here. We believe that we can estimate what the requirements are in the field but have not as yet conferred with those who should know. As to what the costs will be, they vary. In some areas we took certain yardsticks as to the number of beds required per thousand population and studied the different areas in this province. They are not all the same. Some of them have better hospital accommodation than others, and those should be brought up to the point where adequate facilities are available. The same situation applies to the work in the field, that is the preventive work. In some areas more attention has been paid to the application of medical science in the field of prevention. Some plan that can be agreed upon by this group as best serving the preventive side of the provinces is under consideration of the group of deputy ministers, and we have the benefit of the experience of each one of those in bringing in a conjointed plan all across Canada, for the application of preventive measures.

With respect to the last question that Dr. McCann asked, as to the reaction of people to this whole plan, we look to our members of parliament to get that. They are the elected representatives of the people, and we can as deputy ministers judge the reaction of the various ministers in the house of the various provinces as to what that reaction is, and speaking for Ontario alone the fact that practically every elected representative is wanting to know more about this seems to indicate he is being asked a lot of questions about it.

Mr. McCANN: I wanted you to indicate whether you had heard general complaints or acquiescence.

Dr. McGHIE: I only can speak through the representatives of the people who come, and they are all anxious that some steps be taken to meet the demand that is coming from the public generally for some better type of service.

Mr. KINLEY: Have you taken into consideration the real cost of this service to the people? For instance, we talk about the farmer. I know in my county if a fisherman sends for a doctor once it may cost him \$15. It seems to me the real cost is the cost of this over and above what we are paying now individually, which may not be very much.

Dr. McGHIE: I think perhaps, speaking for myself anyway, the money that is spent now on medical care—we are speaking of medical care and prevention as two different things—we think it should be brought closer together; if it were more equitably spread, of course, in the province of Ontario anyway the cost then to the person who is isolated should not be as great and he should get better attention and service.

Mr. McCANN: What is the answer to the other question? How about International Nickel; how about the gold mines like Kerr Addison, and organizations like the Associated Medical Services; what is their reaction going to be about being brought in under this scheme, or can you express an opinion?

Dr. McGHIE: No, I am not in a position to express an opinion; it depends on whether you are thinking of the efficiency of the mines or the employees; it varies.

Mr. McCANN: Considerably.

Dr. MCGHIE: There are many excellent plans set up in the province of Ontario, many excellent schemes that are away ahead of the provincial program as a whole, but in many of the smaller companies they are not in a position to make use of those schemes and they lag far behind as a provincial quota.

Mr. MACINNIS: I should like to ask Dr. McGhie if he does not think that many of these large industrial firms are in a preferred class regardless of what the excellence of the services they give may be. For instance, I understand that at the Hollinger mine before an employee is taken on he must be, I think, below the age of 30, possibly considerably below the age of 30; he must be fit, a certain height, certain weight and of a certain physical fitness, almost as well as if he were being taken into the armed forces. Now, I say they are in a preferred class because they have the pick of the people as regards health. Then, when a person becomes mentally ill he is no longer a charge upon the medical services of the industry. There is the whole question there that a great many people economically as compared with the rest of the population are in a preferred class and have more privileges than the community as a whole. I think the purpose of this health insurance scheme is to spread the cost of health over the people as a whole; and if it is going to fulfil its purpose of giving better health, surely we will have compensation in increased health production and less health costs over a short period of time.

Then, there is another point. I think there should be a great deal of saving. I do not know—probably Dr. McCann knows—the amount of money spent on proprietary medicine by people and particularly people with not very much understanding of health. They spend an enormous amount of money in the course of a year on these medicines. By better education and more attention to health a great deal of that money could be saved and it would be saved in the only way that saving can be made, in a proper way.

Mrs. CASSELMAN: There is another measure before the committee now, a measure known as physical fitness. Would the deputy ministers care to express any opinion on that as a matter in the prevention of disease? I am now referring to an increased program of physical fitness.

The CHAIRMAN: Will you comment, Dr. Jackson?

Dr. JACKSON: Mr. Chairman, I can speak, of course, only for myself on this particular subject; but as it appears to me this is one of the essential things we have been lacking in our communities for the last few years. We attempted in Manitoba, about three years ago, to ascertain the amount of physical disability among our teen-aged members of the high school, and the results we got were simply appalling. We are indeed glad to see there is some consideration being given to an Act along this line, because we feel it will be all to the good. We would like to see some provision, however, if it is possible, whereby in the course of the examination of those young people the defects that are found can be remedied. Our difficulty is now, due to lack of finances of the individual, and due to the scarcity of medical care, to get the defects which are found remedied; in other words, to put people in a fit condition to take full advantage of this plan of physical fitness. We think in Manitoba it is a very desirable thing.

Dr. HEAGERTY: Well, in considering the question of physical fitness we had in mind the development of the individual. We have taken into consideration the physical defects as they were found in the study made in Manitoba. There, I understand, over 3,000 children were examined and 70 per cent were found to be physically defective. Under the Health Insurance Act preventive medicine will be the big factor in preventing physical defects, so we did not make any provision for that in the physical fitness plan. What we had in mind there was the physical, moral and mental development of the child along the lines that have been in force for so many years in Europe.

Now, with regard to the correction of physical defects that have been found, that will be looked after. We have made provision, however, for the correction of physical defects that can be corrected through physical exercise and all that pertains thereto, so that it is a straight physical fitness bill that bears no relation to the other.

I wonder if I may be permitted, Mr. Chairman, just to revert for a moment to the discussion on the industrial concerns? We have dealt with the subject of those industrial concerns from the standpoint of medical care. I wonder if you would keep that in mind. Dr. McCann used the words "health services." That does not cover, I am sure, what we had in mind; that is, medical care. Those firms do not provide preventive medicine and I want that understood. Perhaps I am talking too forcefully now. The primary object of this whole plan is the prevention of disease and as I said at the outset in my preliminary remarks we want to build up a strong people and to create positive health. If we were concerned only with medical care then it would not be a matter of great importance whether or not those concerns continued in existence; but it must be remembered that under health insurance all the people who are now receiving medical care under those plans will be entitled to the full and complete and direct public health prevention services which will be brought into effect under this Act and which are not now in existence.

Hon. Mr. MACKENZIE: Mr. MacInnis mentioned a moment ago the question of the cost of medical care in Canada. My recollection is it is about \$240,000,000.

Dr. HEAGERTY: The estimate made in 1935 was \$240,500,000 odd. That represents the cost of illness in Canada at the present time, but it includes many things that will not be included in health insurance; for example, there are the private rooms in hospitals. An individual will not be entitled to a private room except in an emergency. Then there are the semi-private rooms. If an individual wishes a semi-private room he will be obliged to pay the difference.

After a very complete study of the cost of illnesses in various countries and the study of the cost of health insurance, we have, as I indicated at the last meeting, I think, ascertained that it will cost us \$18 to provide medical care, \$3.60 for dentistry, making a total of \$21.60. But in addition we must make provision for the children; we must find \$21.60 for the children, and that will require \$26 altogether.

We have made a very close study of it. We have, of course, had many criticisms that have not been based upon statistics. Many guesses have been made in regard to the cost of illness, but we believe that our studies are sound and are based upon sound evidence and that we have provided sufficient money.

Hon. Mr. MACKENZIE: I saw some criticism outside about the administration cost being too high. Your cost is roughly 10 per cent?

Dr. HEAGERTY: We have deliberately estimated all our costs high because we did not wish to deceive the provinces in particular. We wished to know what the costs will be. In some of the plans that are being administered in Canada the cost is 10 per cent. I estimated originally that the cost would be 6 per cent, and I believe the Hollinger representative called my attention to the fact that that was very low; but we think that 10 per cent will provide adequate money, and for administration we think it is too high, as a matter of fact.

Mr. MAYHEW: Mr. Chairman, when Mr. Watson was giving his evidence the other day at page 98 of the report he said, in fact, no actuarial issue is involved in this plan. I wondered on what basis he is basing those estimates. I think it is probably too late to explain it right now, but I think it should be explained further because it leaves to anyone reading the report the belief that the amounts arrived at were purely guesses.

The CHAIRMAN: Can you explain?

Mr. WATSON: There is no difficulty whatsoever in answering that question. The figures arrived at—I had nothing to do with them, I may say—were largely

arrived at by statistics, pure statistics. Although actuaries have to use statistics, in the ordinary sense the statistics involved in ascertaining the cost of medical services in Canada do not involve any actuarial issue. In fire insurance there are no actuarial issues because it is a short-term contract and there is nothing but pure statistical problems involved. But actuarial issues are involved in long-term contracts like life insurance or sickness insurance and unemployment insurance, where there is a complicated formula and rather a long-term contract as well, because the benefit depends on the employment record for five years and on the claim record for three years. But all those issues are very different in health insurance; they do not arise.

Mr. MAYHEW: If you are giving specific benefits there ought to be some basis on which they would be arrived at; if not, you will give the impression to the people that if you do not have money enough under your present plan you would lessen the amount of services that you would give to the people or increase them according to the amount of money that you have on hand.

Mr. WATSON: Mr. Chairman, there is no way in which actuarial technique or procedure or anything that an actuary can do which will control events. Furthermore, notwithstanding what we have put in this bill it is still very general and it may well be that when it comes to be incorporated by the provinces, each province may have certain modifications to put in, so it would be extremely difficult to determine now, with benefits more or less indeterminate, what the cost would be. There is another difficulty and it is this, that the costs will probably vary a great deal from province to province. I think it would be safe to say, perhaps, that in Saskatchewan and Alberta the population averages a good deal younger than in some of the other provinces and probably a good deal healthier for the reason the people who move that way are usually healthy people and therefore their costs will be a good deal lower than in some of the older provinces where the population is older. There are other reasons that will make for higher costs in some provinces. I should think there might be a difference as wide as 35 per cent between the cost in the lowest cost province and the cost in the highest cost province. These issues are certainly not actuarial issues; they are quite beyond the sphere of actuarial technique, where an actuary might be of some help. If I had undertaken to do anything in regard to cost I should have had to inform myself concerning the work of the Bureau of Statistics, and probably learned things that the Bureau of Statistics already knows which, after all, are not actuarial matters.

The CHAIRMAN: Dr. Heagerty, have you any comment to make?

Dr. HEAGERTY: I do not wish to repeat what I have said, but I should like to point out some of these costs for your information. This is an estimate of distribution cost of medical benefits under draft bill for health insurance. Now, these figure are what is being paid, I understand, in the United States and Canada for medical care. In the United States the percentage of total cost for the doctor is 42 per cent of the total, that in Canada we have estimated at 44 per cent of the total cost. That represents \$9.50 per capita for the physician, or a total of \$106,485,500. For hospitalization, exclusive of capital expenditure, in the United States the percentage of expenditure is 16.3, in Canada 16.7, or 3.60. That will be \$3.60 per insured person. Now, these figures are exact figures. In Canada last year there were 13,000,000 hospital days with a few days extra. There are eleven and a half million people in Canada so we estimated at least one day hospitalization. That will be 3.60 per capita with a total estimated cost of \$40,352,400. Nursing amounts to 8.1 per cent in the United States and 8.1 per cent in Canada. The per capita cost is \$1.75, with a total cost of \$19,615,750. Medicines, drugs, serums, vaccines, appliances, amount to 12.9 per cent in the United States, and 11.8 in Canada. That works out to \$2.55 a head, which I think is fairly high—at least so I am told after discussing it with members of

the pharmaceutical association. That gives a total of \$28,582,950. Now, laboratory services are not very high, 2·2 in the United States, 2·8 in Canada, making a total of ·60 per capita or a total of \$6,725,400. Dentistry in the United States, percentage of cost is 18·5 per cent, in Canada 16·7 per cent, \$3.60, making a total of \$40,352,400. You cannot provide health insurance for less than that and certainly it should not cost more than that.

Mr. DONNELLY: Mr. Chairman, we are all very much interested in this bill. We realize the importance of health insurance, but the question in my mind, and I think the question disturbing the minds of the public more than anything else is how much of this money is going to be put by the federal government and how much is going to be put up by the provincial governments and how much by the individual. That is what everybody is asking now. How much is it going to cost, or what is it going to cost the provinces and the individual? If any of these men here can give us an estimate at all of that I am sure we would all like to hear it.

Dr. HEAGERTY: I think, Mr. Chairman, it would be necessary to have reference to the presentation that was made by Mr. Mackenzie at the first meeting. If you will refer to that you will find that the advisory committee have not attempted to set down in hard and fast figures, but has indicated the cost and also indicated the various ways in which that cost may be apportioned as between the dominion and the provinces. That is a matter to be worked out, I take it, by the provinces after consultation with the dominion. All that we could do is to indicate the cost and then refer it to the several governments to decide how those costs will be apportioned. It is not possible for the advisory committee to arrive at a final decision in regard to that question.

The CHAIRMAN: Are there any further questions?

Mr. WRIGHT: I do not suppose these deputy ministers of the provinces are down here without having discussed that matter. I was wondering if they have anything to say in that regard.

The CHAIRMAN: Have you any comment, Dr. Jackson?

The WITNESS: I am afraid not, Mr. Chairman. The only comment I have to make is that it will depend entirely, so far as the provinces are concerned, I would think, on what the financial arrangement between the dominion and the provinces is after the war. As you know, we are on a set financial arrangement now, which is to last for one year following the duration of the war; and until a definite plan is established, we cannot say what the opinion of our governments would be; at least, I cannot, speaking for my own.

The CHAIRMAN: Gentlemen, on your behalf, I should like to express our deep gratitude to the deputy ministers of the various provinces for their presence here to-day and for their very illuminating and interesting statements. We are gratefully in your debt, and we thank you very much. We will now adjourn until Tuesday.

Dr. MCGHIE: Mr. Chairman, on behalf of the deputy ministers, may I thank you for the privilege of being here, and assure you that our committee will hold itself in readiness to give any assistance we can.

The CHAIRMAN: Thank you, Dr. McGhie. The committee will adjourn until Tuesday, April 6, at 11 o'clock a.m.

The committee adjourned at 1.05 p.m. to meet again on Tuesday, April 6, at 11 o'clock a.m.

APPENDIX "A"

PROGRESS OF HOLLINGER'S MEDICAL PLAN

From The Canadian Doctor

During the growth of the mining industry to its present efficient level, it was, and still is, common practice that the health of the employees is guarded by a contract system, which consists of an agreement entered into by the employer, employee and a physician.

This contract stipulates that in return for a deduction not exceeding one dollar per month from the employee's wages, the employee receives services for himself during his period of employment with the mine. This form of practice lends itself to abuses on the part of all parties concerned.

With the improvement of methods and conditions of living, it was inevitable that a similar improvement should take place in the provision of medical services for employed groups, who are the stable portion of the population to-day.

In 1937, the employees of the Hollinger Mine approached organized medicine and indicated their desire to have for themselves and their families, a more or less complete medical service. They also indicated that they were willing to budget their finances and allow the same to be arranged through their wages. As the result of this request, the Hollinger Employees Medical Services Association was formed.

The association provides complete medical services for the employee, his wife and family as well as those dependents who are the total responsibility of the employee. No medical examination is necessary except for the employee as a condition of employment.

In this examination, the employee is safeguarded by a thorough chest examination as well as an X-ray by a specialist in chest diseases. Membership is limited to the employees of the Hollinger Mine. All necessary attention is given in the home, office or hospital.

Where it has been found that the services of a highly-trained specialist in outside centres would be of benefit to the patient, the association has provided the service. The association provides all necessary surgery which is under the supervision and direction of the medical supervisor and a committee comprised of member physicians and surgeons.

Such procedures as major surgery and fractures must have a consultation by a second physician. X-rays are provided under the direction of the attending physician. Hospitalization is carried out on the basis of the provision of a ward bed in a recognized hospital.

The length of hospitalization is under the direction of the attending doctor in combination with the medical executive committee. The experience of unlimited hospitalization has been very satisfactory. There are very few patients who need lengthy hospitalization and it is felt that nursing, X-rays and hospitals act as an aid to the treatment of any patient and are not to be taken as the treatment itself. Therefore this is left in the hands of the attending doctor.

Nursing service is provided where nursing care is required by the doctor. All obstetrical patients, if cared for in the home, receive one day's nursing care. All nurses have to present credentials that they are regularly qualified nurses. No attention is paid to a practical nurse. Obstetrical cases are admitted to the hospital under the association if such cases are deemed to be hospital patients by the attending physician.

If a normal patient wishes to be admitted, such admission can be carried out as the responsibility of the patient herself. Drugs and medicines are provided by the doctors. No limit has been placed on the amount of services received by an employee or his family during one year. Similarly, no limit has been placed on the income level.

The services do not include venereal diseases, alcoholism, dentistry, Workmen's Compensation Board, mental diseases after diagnosis has been established, any condition resulting from violation of the Criminal Code of Canada or of any law or statute of Ontario. Where an accident occurs which is the responsibility of a third party or an insurance company, the association is relieved of such expense even though the services are supplied under the association itself.

To administer the affairs of the association, a committee is elected from the employee members who in turn select an executive committee of five who act as one-half the board of directors. The medical members select from their number a medical supervisor and four other members who act as an executive committee and who comprise the other half of the board of directors.

These committees have regular meetings to deal with matters concerning their respective members. The medical executive committee supervises the various services to be provided to the employees and their families and receive and audit all accounts for payment.

The result of over three years' experience shows that the services provided have been such that relatively few complaints have been registered. One of the perplexing and costly problems is the provision of medical care for cancer patients. It has been found that in a group of 9,300 people one patient suffering from this disease has been discovered each month during the lifetime of the association.

To treat this group of patients and provide necessary hospitalization, as well as X-ray and radium treatment, the average cost has been \$452 per patient. It is quite obvious that a person in the low income group of \$1,500 to \$2,000 cannot afford to pay for costly cancer treatment.

The income of the association is derived from the following sources: \$1.75 per period of 4 weeks for each single employee; \$2.65 per period of 4 weeks from each single employee with dependents, and the married employee; the Hollinger Mine contributes \$1 per employee each period. Added to this there is a service charge of 50 cents per period for the first service rendered to the employee or member of a family and \$1 per period if two or more members receive medical services. The maximum deduction in this regard is \$1 and this was instituted as a penalty for unnecessary home and office calls which have a natural tendency to increase in such an organization.

The income is based on a single payroll deduction and not on an individual basis. The amount received is equivalent to approximately \$15.50 per person in the association. The average number of employees is 3,100, the employees' wives 2,100, children 4,000, and dependents 100, making a total of 9,300.

The method of distribution of the moneys has been to pay the hospitalization, nurses, X-ray and the administration and then pay the doctors pro rata of their accounts from the remainder. This has resulted that in the third year the doctors receive 71 per cent of their accounts passed for payment.

From the angle of finance, several points have arisen. What fee is a fair fee for the doctor or surgeon? A rigid attempt has been made to adhere to the policy of a fair fee for a fair service and to follow the tariff of the Ontario Medical Association.

In similar organizations such as this, the remuneration to the doctor is based on 75 per cent of the tariff that exists in the particular area. If such an amount should be regarded as fair, then one's attention is drawn to the fact that such a fee includes the provision of drugs and medicines.

The amount paid to the doctors represents 71 per cent of the accounts passed for payment and includes drugs and medicines. If \$18 per person per year is available for all the services it would allow the payment of 75 per cent to doctors which will include drugs and medicines, also allow for any epidemics, as well as cost of treatment of patients sent to outside points.

Added to this there would be a small reserve. Therefore \$18 per person per year, or \$1.50 per month is necessary to provide ample services for every person.

Because the present day methods of living, combined with a machine age, demands that the utmost be made of earnings from employed groups, such an association is necessary. It is imperative that the medical profession assume the leadership in such efforts and co-operate with the employer and the employee to provide necessary services of quality on a fair basis to all concerned.

Some definite organization must be available to co-ordinate the doctor, X-ray, hospital and nurse in one effort to re-establish any patient.

Officials of the organization feel that it has made definite progress towards the solution of this problem of the provision of medical services. To that end the management of the Hollinger Mine has not only contributed in a fine fashion, but has shown a keen interest in the employees' interests. This feature, along with the fact that the medical services are provided under a policy of medical control, would seem to indicate that the association has a bright future.

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Canada Social Security

SESSION 1943
HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 5

TUESDAY, APRIL 6, 1943

WITNESSES:

Dr. A. E. Archer, President, Canadian Medical Association;
Dr. Sclater Lewis, President-elect, Canadian Medical Association;
Dr. Charles Vezina, Dean of the Faculty of Medicine, Laval University;
Dr. Léon Gérin-Lajoie, University of Montreal;
Dr. T. C. Routley, General Secretary, Canadian Medical Association;
Dr. Harvey, Associate Secretary, Canadian Medical Association; and
Dr. J. J. Heagerty, Director of Public Health Services, Department
of Pensions and National Health, Ottawa.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

TUESDAY, April 6, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Bourget Breithaupt, Bruce, Casselman, Mrs. (*Edmonton East*), Claxton, Cleaver, Coté, Diefenbaker, Donnelly, Gershaw, Gregory, Howden, Hurtubise, Kinley, Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), Macmillan, McCann, McGregor, McIlraith, Maybank, Mayhew, Picard, Shaw, Veniot, Warren, Wood and Wright.—32.

Dr. A. E. Archer, President, Canadian Medical Association, was called. He introduced the following:—

Dr. Sclater Lewis, President-elect of the Canadian Medical Association;
Dr. Charles Vezina, Dean of the Faculty of Medicine of Laval University;
and President of the French Speaking Physicians of North America;
also President of the French Division of the Canadian Medical Association;

Dr. Léon Gérin-Lajoie of the University of Montreal, and member of the Executive of the Canadian Medical Association;

Dr. T. C. Routley, General Secretary of the Canadian Medical Association, and

Dr. Harvey Agnew, Associate Secretary of the Canadian Medical Association.

Dr. T. C. Routley then read the brief of the Canadian Medical Association.

All the above mentioned doctors, and also Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, were examined by the Committee.

Dr. Léon Gérin-Lajoie tabled letters from Fédération des Sociétés Médicales de la Province de Québec, and Le Collège des Medecins et Chirurgiens de la Province de Québec, authorizing him to speak in their behalf. These letters are printed in the evidence.

The witnesses retired.

On motion of Mr. Mayhew the Committee adjourned at 1.15 p.m. to meet again Friday, April 9, at 11.00 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

April 6, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: We are privileged this morning to hear Dr. Archer, President of the Canadian Medical Association. Dr. Archer, please?

Dr. A. E. ARCHER: Mr. Chairman, members of the Special Committee on Social Security, may I at this time introduce my colleagues who are with me today and who are members of our committee: Dr. Slater Lewis, President-Elect of the Canadian Medical Association; Dr. Charles Vezina, Dean of the Faculty of Medicine of Laval University. Dr. Vezina is the president of the French Society which is known as The French Speaking Physicians of North America and he is also the president this year of the Quebec division of the Canadian Medical Association; Dr. Léon Gérin-Lajoie of the University of Montreal, member of the executive of the Canadian Medical Association; Dr. T. C. Routley, General Secretary of the Canadian Medical Association: and Dr. Harvey Agnew, Associate Secretary of the Canadian Medical Association.

On behalf of my colleagues and myself I would like to assure the committee that we appreciate very greatly the opportunity of being here today to present to you on behalf of the Canadian Medical Association our views on this very important question which you are studying.

It is our purpose this morning to lay before you the broad outline of our views in a submission which has been prepared and which will be read to you by our general secretary, Dr. Routley. Following the presentation of this submission my colleagues and myself will be prepared to answer any questions you may wish to put to us. I shall now call on Dr. Routley.

Dr. T. C. ROUTLEY, General Secretary, Canadian Medical Association, called.

The WITNESS: Mr. Chairman, Mrs. Casselman and gentlemen: The Canadian Medical Association welcomes this opportunity of appearing before the special committee on social security to discuss the problem of health insurance.

WHAT IS THE CANADIAN MEDICAL ASSOCIATION?

History records two notable events in the year 1867: (1) Canada became a confederation. (2) The Canadian Medical Association was founded for the following purposes:—

- (a) To cultivate the science of medicine and surgery.
- (b) To advance the character and honour of the medical profession.
- (c) To promote the public health.
- (d) To elevate the standard of medical and nursing education.
- (e) To assist in the advance of medical education for the good of the public.
- (f) To study and advance by any means in its power, the improvement and standardization of hospitals.
- (g) To conduct research work in connection with medical problems confronting the profession.

- (h) To serve humanity and the medical profession by investigation, study and research.
- (i) To establish branches, to publish scientific literature and to do such other lawful things as are instrumental or conducive to the welfare of the public and the medical profession.

In 1909, the association became incorporated by Act of Parliament of the Dominion of Canada. Each of the nine provinces of Canada has a provincial medical association which is a federated division of The Canadian Medical Association. This means that The Canadian Medical Association, in a most democratic fashion, represents and speaks for nine provincial medical associations of Canada.

Membership in The Canadian Medical Association is voluntary, every Canadian doctor in good standing in his community being eligible for membership. There are registered in Canada approximately 10,600 doctors, 8,500 of whom are English speaking and approximately 2,100 French speaking. Of this total number, The Canadian Medical Association has 6,388 members, of whom over 300 are French speaking. It will be observed that our French speaking membership is numerically and relatively small. Why is that? There are a number of reasons which will also apply to other national organizations in Canada, but the most notable reason is the fact that the Canadian Medical Association Journal—a monthly publication—is printed almost entirely in the English language and therefore does not attract our French speaking medical confreres who have splendid medical journals published in their own language. There is much evidence, however, to support the statement that the Canadian Medical Association in the province of Quebec is growing in influence and favour. In the province of Quebec a joint committee representing the various medical organizations, namely, The Quebec Division of The Canadian Medical Association, the College of Physicians and Surgeons of Quebec, and la Federation de Societes Medicales, has been formed for the express purpose of studying health insurance and obtaining medical opinion on the subject. This committee has authorized The Canadian Medical Association to act as its spokesman in the matter of health insurance.

In respect to great national problems such as health insurance, The Canadian Medical Association has not been content in the other provinces to canvass its members only. On the contrary, the medical profession of Canada as a whole has been invited to make its voice heard in respect to these broad questions, to the end that it can be said without fear of contradiction, that the representations which The Canadian Medical Association now makes to this parliamentary select committee express the considered views of the medical profession as a whole throughout the dominion.

The purpose of this submission is:

1. To emphasize that adequate medical care is essential to the welfare of Canada;
2. To review certain factors which handicap the medical profession in providing adequate medical care;
3. To point out that highly desirable preventive and public health services are now inadequate;
4. To indicate the position of The Canadian Medical Association with respect to state health insurance;
5. To set forth features which should be included in any plan of health insurance;
6. To point out the desirability of avoiding certain weaknesses observed in plans of health insurance in other countries;
7. To make general comments with respect to a number of features to be considered in setting up any plan of health insurance;
8. To show that health insurance can suffice to meet the medical needs of sparsely settled communities;

9. To discuss possible future developments in the years to come in the provision of good health care.

I shall deal first with essential adequate medical care.

It is most essential to the welfare of our people that the medical care provided be not only of the highest standard but be readily available to all. Although our present system of providing medical care is characterized by many desirable features worthy of retention, it is recognized that there are a number of ways in which provision is not made for the full needs of the people at the present time.

To achieve its full destiny Canada must have healthy citizens. Our people can only enjoy full and vigorous health if there be provided for them adequate facilities for medical care (preventive and curative) of the highest standard, which will be readily available to all, irrespective of geographic location and financial status.

It would appear that certain changes are necessary, and to achieve this result the medical profession stands ready to co-operate, for the welfare of the people has always been its primary objective. At the same time the medical profession is proud of the achievements of those who have laid the foundations of medical practice over the centuries. The medical profession has served the people well—caring for the poor, placing patient before self whether it be in time of plague or battle, developing medicine from discovery to discovery, fostering research, preserving what is perhaps the highest code of ethics in the world and attracting to its ranks many of the keenest minds of each generation. It is in the interests of our people that these features of medical practice be preserved.

Handicaps or weaknesses of the present system

The costs of sickness have become an increasing burden to many people, particularly those of moderate income, and have frequently prevented them from taking proper advantage of early diagnosis and treatment.

The extent and value and accuracy of medical knowledge and skill have increased tremendously, but at the same time the cost of this service has also become an increasing burden. The major increase has been due to the increasing complexity and delicacy of diagnostic methods and to the increased utilization of intricate apparatus and highly skilled personnel in treatment.

The diagnostic and "laboratory" equipment of confederation days was limited to a stethoscope and (sometimes, not always) a thermometer. This equipment was the forerunner of the elaborate, complicated and costly, but highly accurate, equipment of our X-ray, pathological, biochemical and other laboratories. The number of hospital beds in Canada has increased from about 400 at the time of confederation to over 100,000 at the present time. The investment in Canada is of some \$250,000,000. In five or six decades the cost of providing hospital service which would be abreast of expanding medical knowledge has gone up from 75 cents per patient per day to an average of around \$3 per patient per day. The cost of medical education has increased five- or sixfold and the time required has been more than doubled.

Medicine has ceased to be a science in which any one man can expect to be able to offer full service. For special diagnosis or for certain curative measures, individuals with special knowledge in selected fields must be called in. This has increased accuracy of diagnosis and efficiency of treatment but it has added to the cost.

True, it could be pointed out that the results attained have more than compensated for additional costs. Better and earlier diagnosis and more effective treatment have shortened illnesses and saved lives beyond computation. Actually, despite increased costs of hospitalization, certain specific illnesses, such as pneumonia, gall bladder operations, cost the patient less for hospitaliza-

tion to-day than at the turn of the century, due to a greatly reduced period of hospitalization. Moreover, costs of medical care have not risen as rapidly over the years as has the general cost of living. Nevertheless, owing to the unpredictability of most illnesses and accidents and the reluctance or inability of most people to budget for illness, some means is necessary of relieving the individual of the burden of the cost of illness at the time when he can least afford to pay these costs.

The section of the community which has suffered most from the increase in cost is that great mass of honest thrifty folk of moderate means. The so-called "indigent" has usually received the medical care he has needed and illness has seldom created a grave financial problem for the well-to-do. But for the man of low or moderate income who desires to pay his way, the possible costs have definitely deterred him in many cases from seeking early advice or agreeing to the proper treatment.

Now, a word about voluntary medical and hospitalization plans. In an effort to alleviate the financial burden of sickness, a number of voluntary medical and/or hospitalization plans have been set up. The better hospitalization plans are known as "Blue Cross Plans". These voluntary plans for medical care, or hospitalization, have been of much assistance to their members when overtaken by illness. Unfortunately there are many areas where these plans do not operate; also, being of a voluntary nature they do not cover all of the employed people of moderate means. Moreover, they seldom provide a complete service nor do they make provision for those who are unable to make any contribution.

The distribution of medical services in the various parts of Canada, urban and rural, is not as it should be if all of our people are to receive full and adequate medical care.

This applies also to health services in general.

A major problem in medical distribution is that of providing adequate medical care in rural districts. Present wartime conditions are abnormal and, therefore, cannot be taken as a basis of discussion, but long before the war it was obvious that there was a heavy concentration of medical practitioners and of health services in general in the urban areas. Now with a large number of rural doctors in the armed forces, the problem is much more acute.

The situation not only makes active treatment difficult to obtain, but it interferes with preventive services. For years infant mortality has been much higher in rural than in urban areas; the same applies to tuberculosis.

Some concentration in cities is logical. It should be pointed out, however, that under our system, some concentration of medical personnel must be expected. Specialists could not be located other than in centres large enough to afford them an adequate clientele; although located in centres, they serve both rural and urban patients. As the more technical or specialized diagnostic and curative procedures can best be done in hospitals, patients must continue to be taken to hospital for such purpose. Frequently the equipment or skilled personnel is only available in large urban hospitals. As it is neither possible nor advisable to set up fully equipped and staffed hospitals in all rural communities, many rural patients will continue to be treated in the larger centres, irrespective of any plan which may be put into effect.

Moreover, it has long been noted that many patients in rural areas, even though a competent physician be available in the community, will drive beyond him to the city for diagnosis or treatment. Resulting from the advent of the motor car and good roads, many doctors formerly able to make a living in a country community have been forced to move to larger centres.

Broad statements to the effect that a large number of rural municipalities are without medical care may convey an erroneous impression. A township or a municipality may not have a resident doctor, yet just beyond the borders of that area might be located several doctors serving the district in question with

fully adequate care. Motor cars, improved highways and telephones have completely changed the former conception of what constitutes the geographic area for a normal rural practice.

Many communities have failed to organize themselves in such a manner as to make the best use of existing legislation or to initiate their own health services.

Dr. McCANN: Are you speaking of conditions prior to the war or the immediate conditions, in this statement?

The WITNESS: Mr. Chairman, I think if I might I would like to relate this brief to pre-war conditions. One might mention that the war has aggravated the conditions, and at the present time a national survey is being made with respect to our health assets and liabilities, the result of which survey might alter this picture somewhat; but I think we should relate this reference, Mr. Chairman, at the moment to pre-war conditions.

Many communities have failed for various reasons to organize themselves to take full advantage of existing legislation which would permit them to develop much needed health services. For instance, in rural areas with inadequate voluntary non-profit hospitals, more municipal or "union" hospitals would have greatly improved health services. For various reasons, among which might be cited economic conditions, lack of understanding and leadership, and even indifference, the public health services in many areas have often been but nominal, or even entirely absent.

3—PREVENTIVE SERVICES INADEQUATE

The present program of preventive medicine in the country is far from adequate. Our major emphasis in the past has been on the cure of disease—on negative health, as it were. There should be more emphasis in the future on positive health, on preventive medicine and public health. It is less costly to prevent disease than cure it, yet our progress in this direction, although steady and gratifying, has been far too slow.

In making these statements there is no implication in the slightest that the provincial, federal and municipal departments of health have not done excellent work. Actually they have accomplished much, frequently under considerable handicap. But the results have been much less than could have been achieved had adequate funds been available. It is unfortunate that, while, in the past, money has been freely available for so many other purposes, yet so much difficulty has been encountered in obtaining adequate funds for effective programs of preventive work and public education on health matters.

HEALTH INSURANCE

4—THE POSITION OF THE CANADIAN MEDICAL ASSOCIATION WITH RESPECT TO HEALTH INSURANCE

Realizing the situation, as already set forth, and that solutions for these difficulties must be found, the Canadian Medical Association has been actively studying the subject of health insurance for nearly fifteen years. In 1934 an outline of a possible plan of health insurance was drawn up and adopted by the council of the association. Studies continued and the principles upon which this outline was based have been reviewed and altered, or re-affirmed, from time to time up to and including the annual meeting of the association in June, 1942.

Principle of Health Insurance Approved

At a largely attended special meeting of the council of the Canadian Medical Association held in Ottawa, January 18th and 19th, 1943, the subject of health insurance was again considered. Previously the council had said

that if health insurance were to be established in Canada it should be along certain lines, but had refrained from recommending it or opposing it. At this time, and for the first time, the council went further. In Ottawa in January, 1943, the council endorsed the principle by passing the following resolution:

WHEREAS the objects of the Canadian Medical Association are:

1. The promotion of health and the prevention of disease; 2. The improvement of health services; 3. The performance of such other lawful things as are incidental or conducive to the welfare of the public; and

WHEREAS the Canadian Medical Association is keenly conscious of the desirability of providing adequate health services to all the people of Canada; and

WHEREAS the Canadian Medical Association has for many years been studying plans for the securing of such health services; therefore be it resolved that: 1. The Canadian Medical Association approves the adoption of the principle of health insurance; 2. The Canadian Medical Association favours a plan of health insurance which will secure the development and provision of the highest standards of health services, preventative and curative, if such plan be fair both to the insured and to all those rendering the services.

5—FEATURES WHICH SHOULD BE INCLUDED IN ANY PLAN OF HEALTH INSURANCE

We visualize for Canada a system of health insurance which will be more all-inclusive, efficient and sound than any which has ever been devised and operated anywhere. It should place much emphasis on the prevention of disease and the development of a high degree of physical fitness, and should also include complete modern diagnostic and curative services. Possibly this full program cannot be immediately instituted in its entirety, because of shortage of trained personnel and of institutions, and possibly because of cost; but the full service should be visualized and planned for. Medical knowledge in the prevention and cure of disease is far ahead of the means for its general utilization by the public.

It is obvious, too, that any plan of health insurance which is not supplemented by a program to ensure better nutrition, better housing and the reduction of worry and anxiety, particularly for those of low and uncertain income, will fail of its objective.

A. Adequate Preventive and Public Health Provision

(i) Reorganization of public health and preventive services is necessary to place more responsibility for various procedures on the family practitioners. Their services must be available for and integrated with the public health officials' program. The family must be the unit and the family doctor the first line of defence in this program;

(ii) Our rapidly expanding knowledge of nutrition should be translated into action—adequate diets should be available to all. This implies not only a vigorous educational program but also a degree of economic security to which reference has previously been made.

(iii) The present knowledge of the value of inoculations, vaccinations and other immunizing and diagnostic procedures in the control and eradication of disease should be fully utilized by the extension of public health services, operating with the assistance of the general practitioner;

(iv) General program of hygiene and sanitation must be promulgated and carried out;

(v) Periodic examinations at suitable intervals should be available to all. The early recognition of disease is the greatest weapon in its mastery;

(vi) Complete examinations of all children should be linked with the means for correcting any deficiencies. This would greatly improve the health of our children.

(vii) A more general application of our present knowledge respecting goitre control could bring about a definite reduction in the frequency of this disease in affected areas. All such cases in Canada should be determined by careful study;

(viii) A well organized program to control venereal disease is necessary throughout the country.

(ix) Fifty thousand Canadians are now suffering from cancer; more than 12,000 die of cancer annually; yet many, if diagnosed and treated early, can be cured. An aggressive program to combat cancer should be an integral part of any health insurance plan.

(x) Tuberculosis might be eradicated from Canada in twenty-five years if facilities be provided for its early recognition and efficient control.

(xi) Maternal welfare—Maternal deaths and disabilities have been markedly lessened, but could be reduced still further by a maternal welfare plan which would incorporate all those features which have proven to be of value.

(xii) Full dental care for children is a prerequisite to good health.

(xiii) Pre-employment examinations would help to direct individuals into employment which would be most suitable for them.

A progressive program for the improvement of the health and physical development of children and young people by supervised playgrounds and controlled exercises and physical fitness program is desirable.

Also, the treatment of certain conditions is closely linked with the housing problem, and some integration of authority should be planned in this respect.

Such a general program would greatly assist in the fight to eliminate certain diseases such as diphtheria, whooping cough, tuberculosis, rickets, typhoid fever and smallpox, and would assist in the reduction in the frequency of many others, such as certain forms of mental disease, rheumatic heart disease, goitre, venereal disease and cancer.

As years pass the cost of curative services might be expected to materially decrease as disease is controlled and physical fitness increased.

B. General Practitioner Services

The fundamental service should be general practitioner service. When medical services are needed, such should be available without cost to the patient at that time. The individual should have the right to choose his medical adviser—and vice versa.

C. Specialists and Consultants

The science of medicine has progressed so rapidly that many conditions call for investigation and treatment by adequately trained and recognized specialists and consultants. This service is invaluable and must be freely available.

D. Additional Diagnostic Services

There should be available for all the people whatever diagnostic aid would be of value. This should include laboratory, radiological and other scientifically recognized diagnostic procedures and should also include consultant services. If necessary, diagnostic facilities should be set up to serve designated areas. In some cases the pooling or centralizing of some of these diagnostic services could reduce overhead and consequent cost.

All necessary diagnostic aids which have been proven to be of scientific value should be available for all the people.

E. Hospitalization

Hospitalization accommodation should be available to all who need it and for such time as they need it.

F. Nursing

A visiting nurse service should be available in the home on the order of the medical adviser. Full time nursing service should be made available upon the authorization of the regional medical adviser.

G. Drugs and Appliances

Drugs and pharmaceutical preparations, as authorized in an official formulary which could be prepared, should be available upon the order of the medical adviser. Appliances, such as spectacles, crutches, artificial legs, etc., should be available within reason when authorized.

H. Dental Services

Dental prophylaxis and care with a stipulated limit should be available to all.

I. Problems Needing Special Attention

There is considerable need for the development of adequate facilities for the rehabilitation of those partially incapacitated by physical and mental illness. Such a program would be both humanitarian and economically sound.

There is need, too, in every province in Canada for more homes for the care of the aged and the infirm.

This also applies to the care of those who are chronically ill.

6. WEAKNESSES OBSERVED IN PLANS OF HEALTH INSURANCE ELSEWHERE SHOULD BE AVOIDED

I pause here to interpolate this remark. If we are wise in Canada, we will endeavour to profit by the mistakes of other countries. Forty countries have introduced health insurance. Some of these plans have been in operation for a great many years. We should look at them carefully. I propose to now deal with some of the weaknesses which we have discovered and which we think should be avoided.

In the setting up of any health insurance measure in Canada, it is highly desirable that we profit by the experiences of other countries. Their health insurance enactments have been studied carefully by your association. To obtain first hand information, the Canadian Medical Association sent its general secretary to Europe in 1937 to study health insurance in operation.

The following weaknesses and omissions observed there and elsewhere should be avoided in Canada:

(a) Limited range of service in some countries.

A plan which provides for general practitioner service only does not provide a complete service. Such arrangement is not fair either to the patient or to those who must render specialist service.

By not providing for hospitalization, patients are either unable to obtain needed hospitalization, or must bear heavy financial burdens, or must accept charity. All too frequently an insurance scheme thus becomes a charity scheme.

(b) Dependents not covered in some plans.

To omit from benefits the dependents of the insured, still requires the breadwinner to finance the major portion of sickness in the average family (somewhat

over two-thirds of the total hospitalized illness in a family with two children and a still higher proportion—nearly four-fifths—in the case of home and office practice).

(c) "Indigents" not covered in some countries.

The inclusion only of those who are employed, or who receive up to a certain income, still makes no provision for the varying but usually large number who are in the group frequently referred to as "indigent" or "near-indigent." From the viewpoint of national health, and particularly from that of preventive medicine, it is most important that this group be covered.

(d) Friendly Societies as "Carriers" found undesirable.

The utilization of friendly or benevolent societies as carriers under the Act in one large national plan has had unfortunate results. Although politically expedient at the time to obtain support for the measure, it has now become obvious that these carriers have introduced a third party between patient and physician and between citizen and government. Over the years these carriers have developed large surpluses and have now become so powerful that, through their membership, they can dictate to the government in insurance matters. In another country they have played politics and have been more concerned with the competition for members than with the medical services rendered.

(e) Inadequate payment for services rendered.

Inadequate payment for services rendered can be of serious concern to the general public for eventually it will result in a lowering of the quality of the service rendered. Physicians, dentists, nurses, technicians and all those rendering specialized or expert service should be compensated in accordance with their investment in years and in money in initial and post graduate training, and with their responsibilities and the arduous nature and dangers of their work. It is vitally important to the health of the nation to ensure that medicine of the future shall continue to attract a large percentage of the keenest young men and women of each generation.

(f) Inadequate provision for necessary diagnostic services.

Some plans do not make provision for adequate diagnosis, such as laboratory and X-ray examinations and consultant services. When required these must be paid for by the patient or, as is frequently the case, be provided on a charity or part-pay basis by hospitals and consultants. This is not conducive to early diagnosis, effective treatment and prompt recovery.

(g) Lack of democratic principles in some plans.

In one well-established plan in a major European country the methods adopted are exceedingly dictatorial and bureaucratic and permit the individual member or those rendering the service little, if any, opportunity for stating grievances or correcting omissions or abuses. Health insurance should be a well-integrated partnership, with all parties concerned—the insured, those rendering the services and the state—given a voice in its direction.

(h) Preventive medicine and public health not emphasized in some plans.

Of utmost importance, most existing plans of health insurance do not lay sufficient stress upon preventive medicine. The emphasis has been largely upon curative medicine. Canada has an opportunity to develop a system of health insurance which, by the inclusion of the preventive features already mentioned, can not only set new standards of health legislation, but can have an effect on our future national health far beyond our comprehension.

7—Additional Features to be Considered in Any Plan of Health Insurance

- (a) In developing a health insurance plan in Canada great care should be taken to ensure that the proposals are sound and sufficiently comprehensive.

The medical profession recommends a complete service of high standard. To the medical profession it will mean great and in some respects unwelcome changes. We are, however, willing to assist in its formation and its operation, provided that it will secure for all the insured a high standard of service, as high or higher than has been available in the past, and will be fair both to the person insured and to those rendering the services.

- (b) Should health insurance be a strictly federal measure or should it be a provincial measure, operating under federal enabling legislation and with federal assistance?

One observes in the public press a great deal of active interest.

We realize that there are advantages in a single nation-wide measure of health insurance. It does appear, however, that there are certain factors which would indicate that health insurance should be introduced on a provincial basis. Provincial plans should be coordinated by federal legislation of an enabling nature. Such federal legislation should outline those standards to which provincial enactments would be expected to conform in order to receive federal subsidies. Our reasons are as follows:

1. Local conditions, such as costs of living, needs for and costs of services, incomes, etc., vary in different provinces.

2. Some degree of variation and experimentation in detail is not without value.

3. It would be much more difficult to draft a federal measure acceptable in detail to all parts of Canada, than to prepare a federal measure which would outline the general provisions only and leave many of the details to be determined in the individual province.

4. By maintaining uniformity in the general structure of the plans to be developed in the different provinces, the problems of later unification, should that prove desirable, would be simplified.

5. Revision of the British North America Act would not be necessary.

Some Form of Federal Control Essential for Uniformity.

If provincial autonomy is to be maintained as suggested above, it is extremely important that a sufficient degree of federal control be retained. This control should be limited to such matters as the extent and the standards of the services, as indicated previously. It is important, however, that control be maintained as it is only through this means that a satisfactory degree of uniformity can be obtained. Unless there is considerable similarity in methods and program in matters of disease prevention and control, the results from the national viewpoint will be jeopardized.

(c) Administration.

FEDERAL. If it eventuate that the federal legislation passed be of an enabling nature, it would follow that the function of the federal government with respect to provincial enactments would be broadly to supervise the operations of these provincial acts in order to determine the eligibility of the provinces to receive the federal subsidies and other assistance provided under the Act.

On this basis it is recommended that the federal administration be under the Minister of National Health, with an advisory dominion council on health insurance.

If federal administration is to be carried out within the Department of Pensions and National Health it should be under a health insurance division, with a director in charge.

PROVINCIAL. In the provinces it is strongly recommended that the plan come under a **NON-POLITICAL INDEPENDENT COMMISSION** which might be responsible to the legislature through the provincial Minister of Health. Because of the vital nature of health care the Canadian Medical Association considers it highly desirable to remove these important health services from the possibility of interference in the continuity of services or personnel by the vicissitudes of political change.

We believe, moreover, that the commission should be so constituted, appointed and empowered that it will possess ample freedom of action and that its members will be representative of and preferably nominated by the various professional and other groups interested in the operation of the Act.

(d) Certain details might wisely be left to the province.

Among these might be:

i. The income level (which might be high enough to include all the residents, or set at an agreed level which might vary in the various provinces) below which the residents would be included under an obligatory plan;

ii. The rate and method of payment for all services, professional and institutional;

iii. The best means of obtaining full preventive and public health services within the province concerned;

iv. The particular means which might be necessary to safeguard the basic necessity of maintaining adequate teaching services in connection with medical faculties and teaching hospitals within the province.

(e) The patient of little or no income should be included.

Those patients, frequently termed "indigents", who cannot pay for adequate health services should be included. It would be grossly unfair, not only to the public, but also to those rendering the health services, to omit this group from the benefits of the plan. Provision for the inclusion of such patients should be specifically made in the federal enabling and provincial Acts.

(f) the plan should be on a contributory basis.

The principle of having those participating in the benefits contribute to the fund would seem to be sound. The individual who shares in the cost of providing the benefits is much more likely to co-operate in keeping down unnecessary calls upon the fund. For those not employed by others, a basis of direct assessment could be worked out.

(g) Remuneration.

The remuneration of those rendering the services required under this plan should be reasonable and in conformity with the high standards of service expected of them. In the case of the medical practitioner (general practitioner), it is obvious that some variation in the basis of remuneration may be necessary in different areas. In some areas a "fee-for-service" basis may be desirable, in others a "capitation" basis (so much per annum per individual on a panel, irrespective of the amount of service rendered) may be preferable; in other areas, particularly certain rural areas where the population is small and scattered, a "salary" basis, or a combination of any two of these three alternative methods may prove desirable. Because of this situation, it is recommended that the method of remuneration, as well as the amount, be left for decision in the individual province after consultation between the commission and representatives of the medical profession.

In the case of the specialist or consultant it would seem necessary to follow a fee-for-service basis.

(h) Medical education must be maintained at a high standard.

Fully trained medical personnel in sufficient numbers are absolutely necessary to any plan of general health insurance. Such are necessary for the health welfare and the future of the nation. If anything happens to the proper teaching of succeeding generations of doctors, scientific medicine dies and with it declines the health of the nation. The truth of this assertion is obvious. Mr. Chairman, I should like to underline that sentence, if I may: If anything happens to the proper teaching of succeeding generations of doctors, scientific medicine dies and with it declines the health of the nation.

Heretofore clinical teaching has been carried on in wards set aside for that purpose; these have usually been the public wards of our large teaching hospitals. The hospital service has either been free to the patient or at minimal rates and the medical attention has been without charge. Although the patients have been available for the bedside discussion and demonstration of methods of examination and treatment, the service has been of the highest standard of excellence and always with the complete co-operation of the patients concerned. Under a health insurance plan in which there would be no longer any group of individuals who would receive so-called "free treatment," there is a possibility that opportunities for clinical teaching may be reduced. While it is anticipated that the long recognized excellence of the quality of diagnosis and treatment in teaching hospitals may alone suffice to ensure a sufficient number of patients, it must be recognized that it is distinctly in the public interest that the popularity of teaching hospitals should be maintained, to the end that teaching may not be curtailed.

(i) The plan should be on an obligatory basis for the income groups specified and should be without exceptions.

In other words, all persons coming within the income brackets stipulated should be required to contribute to the fund and be eligible for benefits and there should be no provision for the exclusion of groups below the income level set for the operation of the Act.

Much of the value of a fully adequate scheme lies in its preventive services. The entire population benefits from the functioning of these services and should contribute to them. Conversely, if preventive measures are not applicable to any groups in a community, not only do these groups suffer, but they may constitute a health menace to others.

There are certain plans operating in parts of Canada with voluntary prepayment for health services, providing either medical care or hospital care, or both. Some of these plans are excellent—as far as they go. But none of these plans, to the best of our knowledge, offer the complete protection—preventive, diagnostic and curative—which we believe is envisioned in the proposal before this committee. Some of these plans do not cover dependents. Others cover dependents but, in one-industry towns, may not cover the scattered townspeople not directly connected with the plant. Any acceptable national or provincial plan should offer more than can any individual plan. These plans deserve great credit for their pioneering service, but it is in the national interest to have all single plans absorbed. With a government subsidy the resultant cost to these industries should be less than under present conditions.

It has been the experience in other countries, notably in Great Britain, that the exclusion of certain groups of individuals and the utilization of existing plans has complicated the situation and made it more difficult to attain ideal results. From the viewpoint of administration, a multiplicity of local arrangements, perhaps overlapping in the one community, creates a situation so chaotic

that efficient operation becomes very difficult. Another difficulty arises when an individual changes his employment or moves to another town. If Canada is to have health insurance, let its action be not hamstrung by lack of vision or courage.

There are within Canada, also, certain groups who do not accept medical services—at least at times. They all, however, have been the beneficiaries of preventive and public health services and most of them, sooner or later, of diagnostic and treatment procedures as well. Apart from this, however, all our citizens have a common community obligation. There is probably no argument which can be advanced in support of the exclusion of certain groups from participation in any plan which was not advanced two or three generations ago in opposition to the inclusion of the general population in a scheme under which all were taxed to support our great public school system, even though all do not avail themselves equally of its privileges. It should be quite proper, of course, for certain individuals, if they so desire, to obtain their health care outside of the provisions of any insurance scheme, even as individuals now use schools which are apart from those provided under the authority of our Public or Separate School Acts.

It should also be proper for any institution or any member of any profession to decline to act under the plan and to offer services in a private capacity under any arrangements which are agreeable to themselves and to their patients, provided these arrangements are not contrary to public interest.

(j) If cash benefits be provided for loss of time through illness, such should be through a separate fund entirely apart from the health insurance fund.

Cash benefits, obviously, are a matter of great importance to the insured. It is entirely true "that a person sick needs financial assistance more than a person well." This is realized, yet from the viewpoint of conscientious medical service cash benefits incorporated in health insurance have introduced serious complications.

In every country where cash compensation for loss of time has been a part of a sickness insurance plan, there has been great dissatisfaction over the complications of operation which have developed and the drain on the common fund because of its inclusion. Because of experience gained in other countries operating a health insurance plan, we strongly recommend that such assistance be provided through some plan to be devised entirely apart from the health insurance plan.

8. Can health insurance meet the medical needs of sparsely settled communities?

The answer is "yes." In areas where a doctor could not make an adequate living on the ordinary basis of remuneration under the plan, the commission could provide a salary adequate enough to prove attractive to our doctors. If district nursing service be provided, as well as adequate diagnostic and reasonable hospitalization facilities, and if reasonable opportunities to get away for post-graduate study or for vacation be made available, our doctors will go to rural areas. If bursaries be made available to permit brilliant young people without adequate financial means to complete the medical course, their services in such areas for a definite period of years could be required. The same effect could be obtained, as has been done in Australia, by offering young men and women opportunities for post-graduate study upon the completion of a definite period of service in rural communities.

9. Health and health preservation in the years to come.

I pause again, Mr. Chairman, to say it would be unthinkable if we in Canada in this day and generation should be thinking in terms of the health of our people without endeavouring to peer into the future and think in terms of optimum health of our people.

During the past two generations more progress has been achieved in making good health care available to all than for the two previous centuries. We anticipate still greater progress in the years to come.

Improved Facilities for Diagnosis:

Better and more readily available diagnostic procedures will do much to still further reduce illness. It is hoped that the present commendable system in many provinces of having certain swabs, smears, blood samples, etc., examined by the Department of Health will be extended. The setting up of branch laboratories has been of tremendous assistance. The establishment of "diagnostic centres" in strategic locations may be anticipated. These could be governed by adequate regulations relating to the nature and quality of service, charges and remuneration and to ethical relations. As the inclusion of people of inadequate means under a health insurance plan may make most hospital outdoor departments unnecessary, some of these facilities might be converted into "diagnostic clinics" or centres for referred patients.

Rural Medicine:

Rural medicine will be better organized in years to come. Good care must be available to all. This does not mean that a highly trained doctor must sit around waiting for a handful of scattered settlers to call for his services, but it does mean that methods will be worked out whereby "positive" health care can be made available to these people. This can be accomplished by adequate district nursing, by a reasonable system of rural hospitals and by providing doctors with sufficient returns to compensate them for the hardships and strain of that type of practice. This will all be made easier by providing good roads and improved methods of transportation.

As for specialist and consultant services, there is no reason why such cannot be made available to rural areas. To a large degree the removal of the economic barrier and better transportation will permit reader consultation at the doctor's office. The bigger problem—that of bringing the specialist or consultant to the rural patient—could, and may be, overcome in a fashion similar to that evolved some years ago in Australia and now widely utilized in military medicine, that is by aerial transport. The day may not be far distant when health service planes could be made available in selected areas to carry specialists and consultants, or even "surgical teams", to seriously sick or injured patients. The same planes could function as "aerial ambulances" to carry patients to hospital. The helicopter type of plane would be particularly valuable for this purpose.

Health Centres:

In certain areas we can foresee the creation of "health centres" such as have been envisioned by the British Medical Planning Commission in its constructive report in 1942. In essence the proposal is as follows:—

The health centre would be a building providing a series of consulting rooms, waiting rooms, a small operating room for minor surgery, laboratories and other accommodation. The general practitioners in the town, or that part of a city, would use these facilities for their office consultations. They would not be in partnership, as in a clinic, but would merely use these facilities in a cooperative manner. Each doctor would have his own patients who in turn have exercised their right to select their own medical adviser. Specialists would see patients

either in the centre or elsewhere. Serious or more difficult cases would be sent to the hospital. Work of the centre would be preventive and educational, as well as diagnostic and curative.

The X-ray department and the laboratories would be available to all participating doctors—so would the dispensary, the secretarial department and the clinical records department. Health visitors and district nurses would have their headquarters at the centre.

A large city might have a number of these centres. We might add that where a hospital is centrally located it would be quite possible to have such office building adjacent to or part of the hospital itself.

Hospitals:

Our present hospital system is excellent, but it will probably show better integration in the years to come. We sincerely hope that we shall always continue to benefit from the services of the great group of voluntary hospitals, lay and religious, which have served our sick for many years. It should be possible, however, without jeopardizing this system, to have hospital construction and equipment in general follow a carefully planned programme based upon provincial and community needs rather than upon unrelated and sometimes overlapping local efforts.

Specially designed hospitals should be available in rural areas. These should not be made more elaborate than is justified by local needs, by professional and technical staff available and by the proximity or otherwise of similar or better facilities. Nor should they be more numerous than is necessary to meet local conditions. As transportation facilities improve, the need for numerous rural hospitals should decrease rather than increase. Moreover, if rural and urban hospitals could be so linked that patients could be quickly transferred when necessary to institutions with more elaborate equipment, the net result should be a reduction of mortality, more rapid convalescence and a definite saving of both skilled personnel and special equipment.

One regrettable gap in our present facilities will surely be corrected—more hospitals for convalescent patients and for those suffering from chronic or incurable illnesses. Actually such provision would be a distinct economy.

Should these improvements be combined with general increase in social security and health planning—assured employment and maintenance, better nutrition, better sanitation, better housing and planned physical programmes—the improvement in national health would be amazing.

Conclusion:

Throughout the last ten years, the Canadian Medical Association has consistently and repeatedly sought to ascertain the opinion of the medical profession on the subject of health insurance. The views expressed in this submission crystallize those opinions.

Since this memorandum was prepared there has been placed in your hands the draft proposals of the Advisory Committee on Health Insurance. While some of us have had the opportunity of seeing these proposals, they have not been seen by our constituent societies. It is our hope that in the immediate future the medical profession throughout Canada will be permitted to examine these proposals in detail and that shortly thereafter we may be in a position to come back to you to discuss those aspects of the proposals upon which you might desire our advice and opinion.

In conclusion, the Canadian Medical Association desires to assure the Special Committee on Social Security that our entire organization, stretching from sea to sea, stands ready to render any assistance in its power towards the solution of one of the country's most important problems, namely, the safeguarding of the health of our people.

The CHAIRMAN: Thank you, Dr. Routley for your very fair and comprehensive statement.

By Mr. Breithaupt:

Q. Mr. Chairman, Dr. Routley referred to playgrounds and to the continuance of the development of playgrounds as part of a health program. A number of cities in Canada, such as the city from which I come, Kitchener, have had playgrounds and have developed them for some years. I would like to ask Dr. Routley whether in his opinion the health of the community in the districts where they have had these playgrounds does show improvement or betterment over the conditions which exist in other cities—as the result of those playgrounds and the exercise taken there?—A. I feel that I am not in possession of sufficient statistical data to answer that question specifically as the matter relates to health, but I can say to the gentleman that evidence is available from our juvenile courts to indicate that supervised playgrounds have greatly assisted in improving the morale of the children in the area of the playground and I think, Mr. Chairman, we might deduce that improved morale and better children probably means better health.

By Mr. Donnelly:

Q. I wonder if Dr. Routley would indicate to the committee, the difference between health insurance as we have it advised here and state medicine?—A. Mr. Chairman, in answer to Dr. Donnelly's question I may say that the word "insurance" I think conveys to the mind of all of us the paying of premiums: money is involved and services are purchased. Health insurance envisages a plan whereby money is pooled, and those providing the services to the insured are paid from this fund. State medicine, on the other hand is something very different. State medicine would be a plan in which the doctors and the other health workers would be employed by and paid by and directed by the state. I might say, sir, that the terms "health insurance" and "state medicine" are practically used interchangeably as if they were much the same thing where, as a matter of fact, they are very much the opposite of each other.

By Mr. Cleaver:

Q. Mr. Chairman, there are three questions I would like to ask Dr. Routley. If I understood your presentation correctly, Dr. Routley, you expressed the opinion that the provincial commission to administer the Act should be composed in the main of professional men. Would you please indicate in what way you believe the patient should have representation on the administration commission?—A. Mr. Chairman, the spokesman for the Canadian Medical Association is our president, Dr. Archer. Upon instruction I presented this brief, but I might defer to our president to have him indicate whether or not he will answer these questions or designate one of his colleagues for that purpose.

Dr. ARCHER: I would be glad to have Dr. Routley answer that question, and I might say that if you read the submission closely it is suggested that in the administration of the Provincial Act we are recommending an independent commission which may report to the legislature through the Ministry of Health. We suggest that there should be adequate representation of those who are interested. In this submission we are not suggesting that there is predominant representation of the medical profession, but those who are concerned with the whole problem are all to have representation on the commission, and we suggest that either on the commission or on the advisory committee on health insurance there will be representation of all the groups concerned. Now, it is impossible for me, on behalf of the profession, to answer this question at all in detail, because this is one of the things upon which the profession in the various provinces are far from being in agreement upon as to exactly what form of commission would be the

best form in a particular province; but in general we favour the idea that those who are concerned should have representation either on the commission—if the commission is very small, not all groups can have representation—but either on the commission itself or on the advisory committee on health insurance.

MR. CLEAVER: Thank you, Dr. Archer. My next question was—again if I understood the first reading of your presentation correctly, I understood you and your association to recommend that specialists should be paid exclusively on the fee basis: would you please elaborate why they should be paid on a fee basis and not on a part salary and part fee basis.

THE WITNESS: Doctors are paid on one of several forms of remuneration which, perhaps, I should place upon the record. A fee for a service is a method by which a patient goes to the doctor and receives some service and then pays for that service; capitation as is used in some countries means that the patient receives a service from a doctor for a given period, say, a year, for any medical care that may be required, and irrespective of the kind of care provided by the doctor to that patient a fixed amount of money is paid for that service. We have in this country the municipal doctor who is paid on a salary contract basis. Now, to return to Mr. Cleaver's question: it has been argued that the general practitioner could, perhaps, serve under health insurance on the capitation basis. You will observe, Mr. Chairman, that our brief makes no representations and no recommendation with respect thereto, other than to say that we feel that the method of remuneration should be left in each province to the commission and the profession of that province.

MR. CLEAVER: I understood the brief to say that in regard to specialists you did recommend that they be paid on a fee basis.

THE WITNESS: Right. With regard to specialists I think it would be essential that they be paid on a fee-for-services basis, because it would be extremely difficult, if not impossible, to arrive at any arithmetical formula by which you could put a specialist on a capitation scheme. Specialists may be called in to perform three or four operations in one family in one year or a specialist might not be called in at all, but we do envisage in health insurance that the insured population will relate themselves to a family doctor; whether that family doctor is paid a fee for services or capitation remains to be worked out. We do not suggest, nor do we think it practicable, for all the insured population to relate themselves to specialists on a specialists' roll; therefore we think the two cases are dissimilar.

By Mr. Donnelly:

Q. Would you just designate the differentiation between a specialist and a general practitioner and how you propose to show the difference between the two? Would you designate what a specialist is so that every man cannot say he is a specialist?—A. It is our hope, Mr. Chairman, that when health insurance becomes operated in Canada that those doctors of our profession who hold themselves out to be specialists will be men who are recognized as specialists and certified as such by competent authority. We have in Canada a body called The Royal College of Physicians and Surgeons of Canada incorporated by Act of this parliament and representing those who are especially trained throughout Canada, and we have recommended that the Royal College be asked to certify all those members of our profession who hold themselves out as specialists. Now, a specialist, of course, should be a man who has had training and experience which obviously equips him to say that in his chosen field, which is a limited field of medicine, he is more competent in that field than the general practitioner; and if he is going to limit his work to one field it has been long since recognized that he is entitled to higher fees for that work.

By Mr. Cleaver:

Q. My third question, Mr. Chairman—and I am a bit reticent to ask this question—is this—this is a thought which I know is quite prevalent among a lot of people in Canada to-day; it has to do solely with curative measures as opposed to preventive measures. In the higher trained fields of industrial endeavour mass production is the main thought to-day and we have found that skilled workmen, doing the same restricted operation many many times over, become much more efficient and can do that particular job much better and much more quickly than others. Now, I have not heard any comment in your brief to-day with regard to that subject with respect to medicine. You did make the statement, doctor, that medical science has now reached the point where one man cannot hope to have all of the knowledge of medical science. Is it your opinion that efficiency could be further increased and costs of the services further reduced by carrying specialization to a much greater degree than is being carried to-day, namely, that one surgeon would confine all of his operations in the larger centres to the removal, say, of the appendix; would that increase the efficiency and reduce the cost of that operation?—A. As one who has been twenty-five years in medical administration rather than in medical practice I defer to my president to answer that question.

Dr. ARCHER: The whole field of specialization is very intricate and very important, and it must be fully maintained and developed. Such specialization as has been suggested by the questioner I do not think we visualize or would want to visualize, because I do not think it would add to efficiency; we cannot segmentalize patients in the way that is suggested, we are not mechanical. One of the difficulties in the trend toward specialization is that there is a tendency for the specialists who see a patient to see only a part of a patient, and it is very essential that someone shall see the whole patient; and it is very important that specialization be retained in a proper perspective. It must be maintained and it must be developed, but not too far.

By Mr. MacInnis:

Q. Mr. Chairman, I wonder if Dr. Routley could explain this point: he mentioned that the patient under the insurance plan should have the right to choose his doctor and vice versa. I wonder how the doctor could discriminate as to choosing his patient? I can understand the one but I cannot understand the other.—A. Well, in the British Isles, under national health insurance, the patient has the right every quarter to nominate the doctor on whose panel he wishes to go, and within certain limits each doctor may have so many patients on his panel. Now, there are a certain number of patients in Britain who have been assigned to doctors' panels because neither the patient nor the doctor apparently find it convenient or satisfactory to mutually agree upon a relationship; therefore, I presume, Mr. Chairman, that while the patient has the right to choose his own doctor where more than one doctor is in the same area there should also be left to the doctor the right to indicate to a patient that he would prefer that he went to somebody else. It does seem to me that the relationship between doctor and patient being so confidential and one in which mutual confidence and trust bulks so largely—that we should always be very sure that both the patient and the doctor have the right doctor-patient relationship. Therefore, I think the patient should know, if he is on a doctor's panel, that the doctor is glad to have him there.

By Mr. McCann:

Q. Mr. Chairman, Dr. Routley was present at the last meeting and he no doubt heard Dr. Jackson speaking on behalf of the deputy ministers with reference to the type of administrative detail of the provinces. Now, what was recommended on behalf of the deputy ministers of health was somewhat

different from what has been recommended by the Canadian Medical Association. The Canadian Medical Association, as I understand it, would be favourable to an independent commission type of administration in the provinces if a system were set up whereby it became the provincial responsibility, whereas Dr. Jackson's thought was that the administration of the Act should be a part of the provincial Department of Health.

Now, would Dr. Routley like to comment on that and indicate whether or not there would likely be any clash of opinion as to which would be the better type of administrative unit?—A. Mr. Chairman, that question has engaged the attention of our association and its component part over a number of years. It is one that we have given much thought to. I must go back to what we said in the brief, that we prefer to leave the decision of administration to each province. It is our view that if that is done we will not find one pattern of administration in Canada but we will probably find several. Now, as to commission versus administration in the Department of Health I am obliged to say that it is the considered opinion of the Canadian Medical Association as stated in our brief that we prefer administration by a commission. I would like, sir, if I may, to ask our president to develop that point.

Dr. ARCHER: Mr. Chairman, we are hampered at the present time by the fact that we have not any unanimity across Canada on this matter from our constituent societies, and all we can say is to say that this is one of the things which is very important. We have elaborated at some length in our brief our reasons for thinking an independent commission is of value, but there is no unanimity as to the type of commission, and we said toward the end of our submission that we hoped we would have an opportunity of coming back to you a little later after the various constituent societies have an opportunity of studying the draft proposals in detail and we can make further representations to you; but this would be one of the things upon which we would want the advice of our provincial organizations.

By Mr. Kinley:

Q. I wonder if you could tell us how many doctors in Canada have dominion status—that is have passed examinations of the Dominion Medical Council?—

A. I have not those figures, Mr. Chairman, but they can be obtained very readily from Dr. John Fenton Argue of Ottawa who is the registrar of the Dominion Medical Council.

Q. You would have a general idea of whether the percentage was large or small?—A. I think the percentage is high, sir. The Medical Council of Canada has been conducting examinations since 1912—thirty-one years—and I believe I am correct in saying that at the present time practically all our graduates, our Canadian graduates, take the Medical Council of Canada examination. My colleague says that that is not fully true but a very high percentage take the Medical Council examination.

An Hon. MEMBER: Even in Quebec?

The WITNESS: Perhaps Dr. Lewis could answer that.

Dr. LEWIS: I think, probably, Dean Vézina could answer that question better than I could regarding the French candidates, but a very large percentage of the English graduates take the councillor examination, but Dean Vézina would be able to answer better for the universities of Montreal and Laval.

Mr. GERSHAW: Dr. Routley spoke of the importance of nutrition during times of sickness. Now, I would like to have him comment a little more on this problem of cash benefits in connection with the Workmen's Compensation Board. The two are rather closely associated. Dr. Routley has investigated conditions in other countries, and I would like to have him discuss the cash benefit problem further.

THE WITNESS: It is our view, Mr. Chairman, from observations which we have made that while cash benefits as we say in this submission are essential in the home where there is illness, they should be separated out from the administration of the Health Insurance Act, because we find in the circumstances we have studied that the doctor who is concerned most with the amount of cash benefit involved in any particular illness has found it to be a source of embarrassment and a subject of irritation and one which he feels he should not be concerned with. You will appreciate, I am sure, Mr. Chairman, ladies and gentlemen, that the patient may be influenced in the choice or retention of a doctor by the doctor's attitude toward the time factor for which cash benefits should be paid. Now, it is our view that the relationship between doctor and patient in a given illness should not be coloured or influenced by that patient saying to the doctor: Don't you think that I should have another week off, doctor, it will give me another week's cash benefits; and the doctor may feel: well, I think the patient would be better to go back to work. But you see that if a doctor refuses to grant the cash benefit the patient might put his name on some other doctor's panel in the next quarter. Therefore, I think you have introduced a disability between doctor and patient which is alleged by those who have studied the subject carefully to be not in the best interests of either the patient or his attending physician. Now, we hasten to add: cash benefits? Yes; but put them in the Unemployment Insurance Act. I may say, sir, that one of the largest unions in England—I think it is the railway union—has cash benefits, but they long since separated them from their medical benefits, and the leader of that organization told me that they had no difficulty whatever in controlling the cash benefits, having separated them from medical benefits. Therefore, I do not think it is fundamental under a health insurance Act that cash benefits be in it; on the contrary, I think it would be a great mistake to include them.

By Mr. MacInnis:

Q. On whose say-so would they get the cash benefit? How can you dissociate medical attendance from the cash benefit end of it, because it will be dependent, in my judgment, almost entirely upon the certificate of the attending doctor as to whether or not the person was incapacitated for a certain length of time; how can you separate the two?—A. Opinion differs in Britain on that point. I think the majority of opinion, of medical opinion, would be that a medical certification for cash benefit is necessary, which means that the medical profession may have to certify for cash benefits, but I wish to add that there is strong, and a considerable body of opinion in Britain which would say that cash benefits can be controlled without medical certification and without endangering the fund. I think it is a subject that requires careful examination, and I am not prepared to argue the merits of the one against the other, although I am bound to say that I think medical certification may be necessary.

By Hon. Mr. Mackenzie:

Q. I have just one question I should like to ask Dr. Routley. Two or three times, Doctor, in your submission you referred to the income bracket. I wished to inquire whether you have in mind that possibly the provinces, in their legislation, might have an upper ceiling of income brackets with regard to those who would not come under this scheme.—A. I think the answer would be "yes."

MR. KINLEY: In the presentation I think a new issue, and an issue that is rather important, was brought out. That was that health insurance should be divorced from social security in its administration and in many of its aspects. I think you differ from the Beveridge report, because one of the cardinal features of the Beveridge report is co-ordination and simplification. Have you thought that out at all?

Hon. Mr. MACKENZIE: Mr. Kinley, may I refer to that point before Dr. Routley replies. The Beveridge report definitely recognizes that health insurance be not under the ministry of social security proposed in its recommendations. In other words, in the report mentioned in the submission of Dr. Routley this morning of the medical planning commission in Great Britain which was submitting a cognate report at the same time as the Beveridge report came out, they have definitely recommended that health insurance be not under the administration of social security.

Mr. KINLEY: But I think the Beveridge report makes centralization one of its main points—one contribution, one pool, one administration—and takes away all the drapery which surrounds these things and makes them very difficult. If we in Canada, for instance, accept the idea which seems to be most advantageous,—that is, of enabling and directing legislation in the provinces,—it seems to me, from the viewpoint I have in industry and the viewpoint I have gained through a lifetime in the drug business too, that the provinces should be able to co-ordinate their efforts,—that mothers' allowances, old age pensions, compensation and health insurance should be under one directing body and the whole thing co-ordinated, because they are all interrelated. If we stress the idea that health insurance should be an item by itself, divorced from the other things, I think we will be bringing into being more things which will irritate the people who have to conform to the legislation.

The CHAIRMAN: Dr. Vézina, would you care to make your statement now?

Dr. CHARLES VÉZINA: Mr. Chairman, our students are less interested in taking out Dominion licences than the students of the other provinces, but there were years when some twenty to twenty-two students out of fifty to fifty-five tried the examinations for the Dominion licence.

Mr. LALONDE: From your university only?

Dr. VÉZINA: From Laval University and the University of Montreal.

Mr. BLANCHETTE: What does a student stand to gain from trying the Dominion examinations?

Dr. VÉZINA: It would possibly be less advantageous for the students of the province of Quebec, because most of our doctors practise their profession in the province of Quebec, while, as there are several English provinces, Toronto students or students graduating from McGill University may go and practise their profession in the West, and vice versa.

Mr. PICARD: Mr. Chairman, I understand that at the present time many of the provinces have district health officers, physicians and district nurses whose main duty, if my understanding is correct, is to lecture and to make inspections of schools and so on and to act in cases where there are epidemics. Is there any intention under the present plan to carry on such activities which are more or less of a preventive nature, and would it be the intention to carry on these activities independent of the curative services given? If so, what would be the position? The man who is acting as health officer now has a right to carry on a private practice, because the small unit that is given to him would not provide him with enough on which to live decently. Would the same man, if he is acting in that preventive capacity, be allowed under the new scheme to have a panel, as you mentioned, and to carry on a sort of private practice? There is another point which occurs to my mind. In rural districts where shall the line of demarcation be between his official duties and his private duties?

The WITNESS: Mr. Chairman, speaking for the Canadian Medical Association, it is our view and our hope that preventive medicine and curative medicine will be much more closely related and interdigitated than it now is, and that all of the services which the questioner speaks of will not only be continued but will be more closely related to curative practice in medicine. We want to see a continuation of these preventive services and an extension of them. Certainly

nothing in our minds would interfere with that nor would interfere with the right of the practitioner to perform all other services for which he is qualified.

Mr. PICARD: My point is as to whether or not the same officer would be in a position to do both services, either partly on a salary basis and partly on a fee or capitation basis?

The WITNESS: The answer is "yes".

Mr. PICARD: There is another point about which I should like to ask, and that is as to the fees and the cost. Has the association any standard on which such fees can be based in different parts of Canada? The total cost of health insurance in Canada was mentioned by Dr. Heagerty. Was that question of fees taken into account when they gave us the total figure for the cost of insurance in Canada?

Dr. HEAGERTY: I think perhaps I should answer the first question that you raised. I think you had reference to the health units in the province of Quebec, if I am not mistaken.

Mr. PICARD: Yes. And I understand there are some in other provinces.

Dr. HEAGERTY: Yes, there are some in other provinces. Perhaps I might explain that a health unit is a miniature department of health which is set down in a rural area, usually. It might take in an urban area or might be part urban and part rural. It takes in one county or perhaps more than one county. The staff comprises a highly trained public health doctor, and usually there is a fully qualified public health nurse, either a sanitary engineer or sanitarian and other personnel as required. At first, in the province of Quebec, public health only was the object of the unit sanitaire. But latterly there has been an expansion into the field of diagnosis, particularly in respect of tuberculosis. So that the medical officer in charge of the health unit is now making some diagnosis; and as a matter of fact, the health unit is being utilized as a centre. It is the intention to put into each health unit a dentist; and in fact there is a dentist in some of them now. So that there is, as you can readily see, a tendency to expand from the field of preventive medicine into the field of diagnosis and treatment. I discussed that with Dr. Grégoire as to the province of Quebec; and he said, that, in so far as it was possible to do so, there would be a desire on his part, if health insurance were adopted in Quebec, to use that unit not only for the purpose of preventive medicine but also for diagnosis and treatment. It will not be possible always, however, to use that unit for that purpose, as in each unit there is not a hospital. But that is the tendency at the present time.

Mr. LALONDE: Mr. Chairman, I am not quite familiar with the organization of the Canadian Medical Association because I am a lawyer. But I should like to have from the delegation from the province of Quebec a definite statement to the effect that the brief so eloquently presented this morning by the Canadian Medical Association represents the opinion of the medical profession in Quebec as well, if that is so. I mean, I should like to know.

Dr. GÉRIN-LAJOIE: Mr. Chairman, it was stated last week, I think by Dr. Grégoire, that the association of French doctors of North America was representative of the French-speaking doctors of the province of Quebec. I believe that statement was made in good faith; and, in a way, it is partially true. But on the other hand, as its name states, the French-speaking doctors of North America are composed of all the doctors speaking French not only in the province of Quebec but in Canada, the United States, particularly in the New England states and Louisiana, Mexico, even central America and South America. Therefore I believe it should be considered rather as an international organization. Probably the greater number are recruited in the province of Quebec. But up to the present time this association, international in name and in fact, has not dealt with the particular question of health insurance. In

the brief, if you have listened to it attentively, you will have noticed that there has been formed in the province of Quebec a joint committee, composed of the Quebec division of the Canadian Medical Association, the *Fédération des Sociétés Médicales* and *Le Collège des Médecins et Chirurgiens*. This joint committee has met quite a few times to discuss this matter of health insurance, and it has agreed to name the Canadian Medical Association as its spokesman in all details referring to health insurance—at least, regarding what is considered the federal part of it. I have here in this envelope the authority from the president of the college, Dr. Desrochers and Dr. Cholette, president of *Fédération des Sociétés Médicales*, to take the stand and speak here in their names. What I have stated here represents the views of all the French speaking doctors of the province of Quebec. *La Fédération des Sociétés Médicales* states that it has a membership of about 2,000. There are about 2,000 French doctors in the province of Quebec, but this federation has one or two English societies affiliated with it. Moreover, the college, being the official body, represents all the members of the medical profession in the province, English and French. Therefore we feel that the Canadian Medical Association, through its representatives here, and myself in particular, approve of this brief twice, through the federation and through the college.

Mr. VENIOT: Mr. Chairman, we have with us here to-day Dr. Vézina, who has already addressed this gathering. But perhaps it has not been drawn to your attention that he fulfils two or three functions. He is, in the first place, Dean of the Medical School of Laval University at Quebec. Secondly, he is President of the Quebec Division of the Canadian Medical Association, for which Dr. Gérin-Lajoie has just spoken. Thirdly, he is also President of this association of French-speaking doctors of North America to which Dr. Gérin-Lajoie has made reference. Perhaps Dr. Vézina would like to lend his support to Dr. Gérin-Lajoie and say what authority Dr. Gérin-Lajoie has to speak for the medical organization in the province of Quebec.

The CHAIRMAN: Dr. Vézina.

Dr. VÉZINA: The Association des médecins de langue française de l'Amérique du Nord, as Doctor Gérin-Lajoie has just told you, is an association embracing the French-speaking doctors of the whole of North America. It is an association mainly devoted to scientific pursuits and one of its objects is to foster French culture among the French-speaking doctors of North America. In a word, it is an exclusively Canadian association.

We have not studied this question of health insurance. On the other hand, the French-speaking doctors in Canada who belong to the Association des médecins de langue française de l'Amérique du Nord are all subject to the Collège des Médecins de la province de Québec, which is our official organization, and, from what I understand, the Collège des Médecins as well as the *Fédération des sociétés médicales* de la province de Québec, approve the plan presented by the Canadian Medical Association.

Mr. DONNELLY: Dr. Routley, a little while ago Mr. Kinley referred to social security legislation and national health, and referred to the fact that you, in your brief, had expressed the opinion that they should be kept separate. Can you tell this committee whether they are kept separate in New Zealand or whether they are all in one scheme or plan there?

Mr. McCANN: Mr. Chairman, may I just say a word there, so that it will fit in properly in the record, if Dr. Donnelly will excuse me. Will Dr. Gérin-Lajoie put on the record the letter which he says authorizes him to speak for the association?

Dr. GÉRIN-LAJOIE: Do you want me to read them?

Mr. DONNELLY: Just table them.

The letters referred to are as follows:

FÉDÉRATION DES SOCIÉTÉS MÉDICALES DE LA PROVINCE
DE QUÉBEC

(Translation)

MONTREAL, April 5, 1943.

Doctor LÉON GÉRIN-LAJOIE,
1414, Drummond Street,
Montreal, Que.

The Fédération des Sociétés Médicales de la Province de Québec, representing 28 medical societies (with a membership of about 2,000), has formed, with the Collège des Médecins et Chirurgiens and the Canadian Medical Association, a special committee to study the health insurance plan presently before the Canadian House of Commons.

Doctor Léon Gérin-Lajoie is one of the members of this committee to whom we have assigned the task of defending our interests.

Doctor A. M. CHOLETTE,
*President of the Fédération des Sociétés
Médicales.*

LE COLLÈGE DES MÉDECINS ET CHIRURGIENS DE LA PRO-
VINCE DE QUÉBEC

(Translation)

MONTREAL, April 5, 1943.

Doctor LÉON GÉRIN-LAJOIE,
1414, Drummond Street,
Montreal, Que.
My dear Doctor,

The joint Committee of which you are a member and which is composed of the representatives of the Collège des Médecins et Chirurgiens, the Fédération des Sociétés Médicales of the Province and the Quebec division of the Canadian Medical Association, has studied the question of health insurance and reached the conclusions which you know.

Therefore, I request you, when the discussion of these conclusions takes place in Ottawa before the parliamentary committee to which the health insurance plan has been referred for study, to kindly represent the Collège des Médecins et Chirurgiens de la Province de Québec.

Trusting that you will be able to render us this service, I remain,
Dear Doctor,

Yours very truly,

Dr. J. E. DESROCHERS,
President.

The WITNESS: Answering Dr. Donnelly with respect to New Zealand, that part of the Act dealing with monetary benefits is administered under the direction of the Minister of Social Security while that part of the Act dealing with medical and other benefits is administered by the health department under the direction of the Minister of Health.

By Mr. Donnelly:

Q. Do they have sickness benefits there? Do they get so much as a grant during the time of sickness?—A. With regard to sickness benefits, every person over sixteen years of age may make application for sickness benefits, if the claim is supported by medical certificate. There is no benefit for the first seven days. Sickness benefits are the same as unemployment insurance.

Q. Do they have any difficulty in getting their certificates from their doctors there?—A. I fear I cannot answer that, Mr. Chairman. I am sorry.

The CHAIRMAN: Are there any other questions?

By Mr. Hurtubise:

Q. So as to make the record complete and satisfactory to the public mind in every corner, I should like Dr. Routley to make a statement as to what is going to be done, or how the already existing industrial plans and hospital plans are affected under the proposal.—A. Mr. Chairman, I tried to deal with that this morning. I might say, however, Dr. Hurtubise, that we propose that all of these plans be absorbed with the plans which may be set up in any province. As for the views as expressed in the brief, and as will be found in your records, we feel that, taking the long view, it would be in the public interest that these plans all become supplanted by the provincial plan.

Mr. WRIGHT: I wish to bring up a matter which I think is of great importance, coming as I do from a rural constituency in the province of Saskatchewan. We have had tremendous difficulty in obtaining a minimum of medical services in certain districts in that province, even before the war. I do not think that the medical association in that province nor the Canadian Medical Association were particularly interested, or took any active part in seeing that medical services were maintained in those districts. Since the war has been going on now for some four years, conditions in those districts have become rather desperate. I know that in my own constituency we have 3,000 people in one district who are fifty miles from their nearest doctor, though there is a small United Church hospital there without any medical attention other than a trained nurse. I think some attention should be given to this immediately by the government, in conjunction with the medical association.

Mr. DONNELLY: Have you a municipal doctor?

Mr. WRIGHT: No. These are local improvement districts where it has been impossible for them to obtain even a municipal doctor because of economic conditions within those areas. Those conditions are serious and demand, I think, some immediate attention.

Hon. Mr. MACKENZIE: Are those cases where the former doctors have enlisted?

Mr. WRIGHT: Some are cases where the former doctors enlisted. Others are cases where the former doctors, under economic conditions, had to leave. I know some of these men personally. They were very fine men, but economic conditions were such that they had to leave those districts.

Mr. DONNELLY: On account of the small population?

Mr. WRIGHT: No. The population was there, but there just was not enough money in the districts to maintain the doctor. The doctor could not live on cord-wood, and cord-wood was the medium of exchange in many of those districts, although there are hundreds of families, actually, in the districts. That condition maintains in the north of the province; and in the south of the province. Drought conditions produced those conditions and there just was not enough money to maintain doctors in those areas. These conditions are serious now. I think they demand some immediate attention. I think the medical association, in conjunction with the government, should have some allotment of the doctors in the Dominion of Canada, under present conditions, to take

care of some of these areas. I do not see any other alternative to that, except leaving these people in the condition they are in. I know that during this winter mothers had to be taken fifty miles in open sleighs to the nearest hospital to give birth to children. Others—not individual cases but in the hundreds—received no medical attention at all. Those conditions are just not good enough. I think that some immediate attention should be given to them.

The CHAIRMAN: Have you any comment, Dr. Routley?

The WITNESS: Mr. Chairman, the Canadian Medical Association would have me say that it is their very keen desire that wherever our people go, our doctors will go. I think too that you would have me say that as Canada has developed—in fact, as all countries throughout the civilized world have developed—the doctor has been found where the people went. We deplore the fact that in any part of Canada people are without medical care. I again remind you that in our submission this morning we show the ways and means whereby we think and hope medical care will be available to all our Canadian people.

With respect to Mr. Wright's question, may I say that I am familiar with Saskatchewan. I know it pretty well. I homesteaded in that province many years ago, and know something about rural Saskatchewan. I also know one or two areas in that province which he perhaps had in mind, and I know that our medical committee in that province has been struggling for months hoping to find a doctor to go into one of those areas. Our association, Mr. Chairman, has neither the ability nor the power to direct any doctor to go to any place in Canada. We can only influence and persuade. Now, with 3,000 of our doctors in the war services, you will appreciate the fact that those who are left are carrying a heavy burden. But if some plan can be devised for providing doctors to the rural areas, nothing would please our association more. Unfortunately, we have neither the ability nor the authority to provide them ourselves.

Mr. LALONDE: Mr. Chairman, Dr. Routley has said in his brief that around forty nations have adopted a kind of health insurance. Would he be good enough later on, say within a few days, to table the list of those nations, for the convenience of members of the committee?

Hon. Mr. MACKENZIE: The memorandum that is now being printed will contain all that information, and that will be ready in about a week or two.

Mr. PICARD: I do not want to be too bothersome, but a few moments ago I asked one or two questions that I do not think have been answered. If I may be permitted I should like to know if the medical association has any standard on which medical fees, as contemplated in the plan, are based. That is question number one. Then has the total cost of health insurance figured in the plan been taken into account? Has the medical association been consulted and so on? Then I come to question number three. We have been told that the total cost of illness in Canada was so much, which, divided by the population, would be so much per head, and that the premium would be figured on that basis. Is it not admitted that quite a number of people in Canada have never had the opportunity or the chance to get the full medical services to which they were entitled to up until now? So how can we arrive at the definite and correct figure of the cost of illness in Canada? Those are the three questions.

The CHAIRMAN: Dr. Routley, will you answer the first one, please?

The WITNESS: Answering the first question, Mr. Chairman, I may say that the medical profession in the various parts of Canada has a schedule of fees which has been adopted in that area. I think I should leave Dr. Heagerty to answer the other questions.

Dr. HEAGERTY: The second question is a rather difficult one to answer. I do not know that I can answer it with any very great degree of satisfaction to you or to the members of this committee. I think you will remember that,

in the course of my former remarks, I intimated to you that we had made a study of the cost of illness in various countries, including countries in which health insurance had been provided. It was on the basis of those studies that we estimated the per capita cost of health insurance in Canada. Until the provinces have studied their problem—their resources, the number of people for whom health insurance is going to be provided, the facilities that can be offered, the medical benefits and so on,—it will be impossible to arrive at an exact figure. But we believe that the figure we have provided, after a great deal of study of other studies that have been made, is accurate. For example, let me take one study that was carried out at the Department of Agriculture in the United States. That represented a study of 9,000 families in villages and towns in rural areas. That study took into consideration the number of cases of illness in each family, the number of persons who were ill in each family, the number of visits that were made by the doctor, the number of visits that were made for each illness by the doctor, the treatment afforded by the nurses, the number of visits by the nurses, dental treatment and other treatment—every treatment, as a matter of fact, that would apply to an average family group in the community. As a result of that it was ascertained that the amount of money being expended for medical care that will cover all the groups that we have in mind was \$18. That is the amount per person. So we feel that having compared that with other studies of a similar nature that were made in the United States and in Canada we are pretty near to the figure. That, I think, is as clear an answer as I can give you.

MR. PICARD: You mean that the cost has been established not on what you figure out to be actual expenditures in Canada for illness in the past but on experiences carried on in other countries where the insurance plan has been in operation?

DR. HEAGERTY: It has been figured on both. I think I pointed out at a former meeting that in 1935 the Bureau of Statistics in Canada carried out a study of the cost of illness in Canada, and that figured out as \$23 a head. Now, we have excluded from that, of course, certain costs that will not figure in health insurance—private rooms in hospitals and special services and so on—which brings it down to \$18. Therefore, the figures compare very favourably.

MR. PICARD: What I wanted to have clear in my mind was the fact that everybody in Canada up to the moment had not had actual protection in case of illness and so on and this was covered in your estimate of the cost—not on actual figures for the past where many people had not received the services for illness, but actually taken into account should it be given in the future?

DR. HEAGERTY: Yes, that is quite right.

MR. BRUCE: Mr. Chairman, I just wanted to say a word, as a doctor, so that the lay members of this committee may understand what my attitude is in regard to the presentation which was made this morning by Dr. Archer and Dr. Routley, president and general secretary of the Canadian Medical Association respectively. The committee should know that over a long period of years the Canadian Medical Association has made a study of these matters and, therefore, they are in a position to give expert opinion and advice to us as to what we should do in relation to the matter under discussion. Dr. Routley just referred to the fact that the secretary of the Canadian Medical Association had gone abroad to study health insurance measures adopted in other countries. I may say in the event that you do not understand who the gentleman who went abroad was that it was Dr. Routley himself, and it is very fortunate for this committee at this particular time when it is hoped that some measure of health insurance will be put on the statute books that these gentlemen have made a study of this subject for many years—and they are able

to give us out of their own knowledge just what we require to know to enable us to put on the statute books, I hope, a better Act of health insurance than any country heretofore has had. I am not going to delay you, but I just wish to say that I happened to be in England when Mr. Lloyd George brought in his health insurance measure in that country some thirty odd years ago, and I remember the attitude of the medical profession toward health insurance then very well—it was antagonistic. They did not want to have health insurance imposed on them; they did not think it would work. However, Mr. Lloyd George met the members of the medical profession and had a series of meetings and they in a certain way composed their differences and as a consequence the measure which Mr. Lloyd George brought in was reasonably acceptable to the medical profession. It was tried out, and certain modifications were made to make it more acceptable both to the people and to the profession, and ultimately they had an Act which it was possible to operate. Years later I met many of those medical men who had opposed the measure in the beginning and found them now heartily in sympathy with and supporting the Health Insurance Act which was then in force.

In conclusion I would just like to emphasize the fact which will be apparent to everybody that no health insurance plan can operate without the cooperation and support of the medical profession. The regulations and conditions must be such that the medical men will agree to them, because they are the essential people who will carry them out and make them function. It is important to have the Canadian Medical Association approve of the principle of health insurance. For in British Columbia a Health Insurance Act was put on the statute books without securing the cooperation and support of the medical profession and it just did not function. I will only add my personal thanks to Dr. Archer and Dr. Routley for the very lucid and comprehensive presentation they have made which has covered every phase of the subject in a very thorough way, and feel sure that the committee will find when they study this submission that they will get almost all the information they require in it.

The CHAIRMAN: Thank you, Dr. Bruce. I should like to express the sincere thanks of the committee to the members of the Canadian Medical Association who are here to-day. We thank you very much for a most enlightening presentation. We shall adjourn until Friday, April 9th, at 11 o'clock.

The committee adjourned to meet Friday, April 9, at 11 o'clock a.m.

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SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

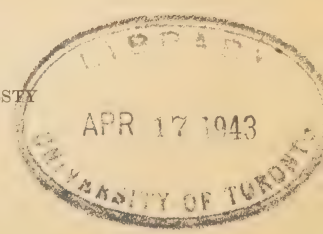
No. 6

FRIDAY, APRIL 9, 1943

WITNESSES:

- Dr. G. J. Wherrett, Secretary of the Canadian Tuberculosis Association.
- Dr. George F. Stephens, President, Canadian Hospital Council.
- Dr. Harvey Agnew, Secretary, Canadian Hospital Council.
- Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health.
- Rev. Fr. F. J. Brennan, London, Ont., member Canadian Hospital Council.
- Rev. Mother Allaire, Montreal, Que., member Canadian Hospital Council, and also the Canadian Catholic Hospital Council.

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1943



MINUTES OF PROCEEDINGS

FRIDAY, April 9, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs: Blanchette, Bruce, Casselman (*Mrs.*) (*Edmonton East*), Cleaver, Cote, Donnelly, Fulford, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Leclerc, Lockhart, MacInnis, MacKenzie (*Vancouver Centre*), Macmillan, McCann, McGregor, Picard, Shaw, Slaght, Veniot, Warren, Wood and Wright.—26.

Dr. G. J. Wherrett, Secretary of the Canadian Tuberculosis Association, was called. He filed a brief which is printed as Appendix A to this day's evidence.

The witness retired.

Dr. Heagerty was recalled and further examined.

Dr. George S. Stephens, President of the Canadian Hospital Council, was called. He introduced Dr. Harvey Agnew, Secretary of the Canadian Hospital Council, who presented the brief for that organization.

Mr. Fulford filed the following documents:

Statistical Report of Sanatoria in the Province of Ontario for the year ended December 31, 1941;

Tuberculosis prevention as an economic factor in Ontario;

Division of Tuberculosis prevention of Ontario Department of Health, Annual Report, 1941;

Report of Ontario Department of Health showing number of patients treated in Sanatoria, etc., 1941;

Report of Ontario Department of Health showing expenditures by municipalities for post-sanatorium care.

Mr. J. C. Brady, Chief of Institutional Statistics, was called, examined and retired.

Dr. Stephens introduced Rev. Fr. F. J. Brennan, of London, Ontario, and Rev. Mother Allaire of Montreal, Quebec, members of the Canadian Hospital Council. They briefly addressed the Committee and retired.

The Chairman thanked the witnesses for their valuable contribution to the evidence.

On motion of Mr. Blanchette, the Committee adjourned at 1.05 p.m., to meet again on Tuesday, April 13th, at 11 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

April 9, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Mr. Shaw, a member of the committee, has a question with reference to tuberculosis and I shall call Dr. G. J. Wherrett, Secretary of the Canadian Tuberculosis Association, to answer the question.

Dr. G. J. WHERRETT, Secretary of the Canadian Tuberculosis Association, called:

By Mr. Shaw:

Q. Mr. Chairman, during the course of his presentation to the committee on March 19, Dr. Heagerty referred to the subject of tuberculosis and the increase in the number of cases. In reply to a question of mine he indicated that not only has there been an actual detection of quite a number of cases of tuberculosis as a result of military examination and so forth, but there has also been an actual increase in the number of cases since the outbreak of the war. What I should like to ask is, would Dr. Heagerty or some representative of the department or the association elaborate upon the statement which was made on that date?—A. Mr. Chairman, in this connection I prepared a memorandum that I thought would cover the outstanding features of tuberculosis and which went into the matter of the increase in tuberculosis since the war. Now, in that connection there has been an increase in tuberculosis, not only in deaths, but in the number of cases reported. In 1940 the death rate was 50 per 100,000; in 1941 it went up to 53. There has been a considerable increase in the number of cases reported, but there are factors that may not have direct relation to the war. For instance, there has been the X-ray of recruits. Every recruit has been X-rayed, and that has meant that there have been from 8,000 to 10,000 cases reported in that way since the war began.

Now, with regard to this matter of increase in tuberculosis in war time, we do not know exactly what is going to happen. The only thing we can do is to take the experience of the last war and what has happened so far in this one. In the first great war tuberculosis increased in every country, particularly in the countries that were definitely involved in the war and particularly in those that were overrun. For instance, figures from the League of Nations tell us that from 1914 to 1918 the rate in Austria went up from 256 to 432; in Belgium it went up from 124 to 245; in Germany from 143 to 230, and in England and Wales it went up from 135 to 192. In the United States it went up from 147 to 150. In this country, taking Ontario as an example, it went up from 88 in 1914 to 93 in 1916. Then it fell off a little in 1917 and 1918 and immediately went down after the war. In England and Wales in 1938 the number of deaths was about 26,000; in 1941 it had gone up to 28,000. That was a greater increase than had happened in the first two years of the first war.

By Mr. Lockhart:

Q. Have you the other provinces; have you any report on the other provinces on that point?—A. Well, in the years of the first war there were no dominion figures at that time; there were some for the provinces, but the figures I have given you for Ontario are the average.

By Mr. Donnelly:

Q. What do you think of the cause here in Ontario?—A. I think that it is easy to understand the increase in England, for instance.

Q. In Ontario?—A. I think it is the increase in all activities, industrial activities and other ways. Young people are going to work two or three years earlier than they were before the war; there is a great disturbance of life of all kinds.

By Mr. Lockhart:

Q. More rigid detection methods, too?—A. Yes, that is true. I think possibly the people moving around as much as they are has something to do with it; they get out of the way of their regular medical attendance and so on, probably they do not get medical attention as soon as they might have in ordinary times. That is true in the first years of the war.

By Mrs. Casselman:

Q. Do you find the increase greater in urban or rural districts?—A. As far as we can make out there is no difference. The increase in 1941 was general all across Canada in the white population.

By Mr. Donnelly:

Q. Is that death rate or detection?—A. The death rate.

By Mr. Howden:

Q. How does the death rate compare with the incidence of the disease?—A. Well, it is so hard to compare them; we find the death rate is the best index because we know exactly. The incidence depends on how well tuberculosis is reported; it also depends on whether the survey has been done in one province and not in another. There may be a lot of cases of tuberculosis in a province that are not discovered.

By Mr. Wright:

Q. What is done with regard to cases that are discovered on entering the army? I ask that question because I had a young chap come to work for me who had been discharged from the army because of tuberculosis, and it was quite evident on talking with him that he had it, and yet apparently he had not been sent to any institution, he was simply turned out without any care being taken in regard to him.—A. Well, now, all these cases were reported by the military authorities to the provincial departments of health and they in turn refer them to their tuberculosis services. Now, of the number that were reported with tuberculosis only about one-third would require treatment, the others had had tuberculosis, it was not safe for them to go into the army, but many of them, although they had tuberculosis, were not infectious, they were not active and did not require treatment. It is possible the chap you have reference to may have been in that category.

By Mr. Wood:

Q. You mentioned treatment amongst the white population. I am led to believe many of the 125,000 Indians have tuberculosis, and that it is quite prevalent among them. Do your figures include the Indian population? Can you give any record of the mortality rate among Indians?—A. Yes, the rate is between ten and twelve times the white rate, the rate in the Indians.

MR. VENIOT: With all deference to the gentleman whose curiosity is aroused, I should like to suggest that the doctor be permitted to complete his statement and the questions be asked afterwards.

Some Hon. MEMBERS: Hear, hear.

The CHAIRMAN: Is it your wish that Dr. Wherrett should read his statement or have it placed on the record?

Mr. LOCKHART: With all due deference to the remark of the last gentleman, these questions are very pertinent on the point where the issue is raised in the doctor's statement. I cannot see that any grievous harm is done by the committee by asking these pertinent questions.

The CHAIRMAN: I think Dr. Veniot was referring to the question of procedure.

By the Chairman:

Q. Do you prefer to answer questions as you go along, or do you prefer to make your statement and have the questions come in at the end of this statement?—A. Whatever you like.

Q. The preference is yours.—A. There are certain things I should like to bring out which I think would interest the committee.

Q. Proceed with your statement and if you wish to stop at some point and have the members ask questions the questions will be accepted.—A. I think you would be interested in the problem as it was in 1941. There were 6,051 deaths from tuberculosis in 1941. That was a rate of 53.1. That represents the deaths. As far as we know there are about 30,000 active cases in Canada that are either requiring treatment in institutions, under treatment in institutions or under treatment at home. There is probably another 30,000 that have recovered and are not under any treatment but need some supervision. It is the greatest cause of death in young adults from age fifteen to age forty-five. Now you may say what is the reduction in tuberculosis that has taken place. If we take 1900 we find this: we have figures in 1900 for Ontario and Quebec, and the rate in Quebec was about 240, the rate in Ontario was about 160, an average of about 200 in 1900. In 1941 it was down to 50, so it was reduced 75 per cent in the figures we have available. In 1921 the Bureau of Statistics was established and we have figures for all the provinces. The reduction from 1921 to 1941 on the average is 39 per cent. The matter of Indian deaths I do not think gives us the true picture of the reduction because the programme of tuberculosis control has been carried on in the white population for many years, but has only been started for five or six years in regard to the Indian problem. So I took the rate for 1921, which the bureau tells me contains very few Indian deaths. At that time they did not report Indian deaths, and I compared them with the 1941 rate without the Indians, and for those two figures there is a reduction of 46 per cent for Canada as a whole in the twenty years, and there is a reduction in the provinces varying from 63 per cent in Ontario to 34 per cent in Quebec. It is interesting to note that that reduction in tuberculosis corresponds very closely with the facilities that have been provided for the care and treatment of tuberculosis. We estimate that for every patient that dies of tuberculosis in any given year there are about three who should be getting sanatorium treatment. There are several provinces that have enough beds, that is to say, Ontario, Manitoba and Saskatchewan. Here are the reductions in those provinces: 63 per cent in Ontario, 58 per cent in Manitoba, and 51 per cent in Saskatchewan.

By Mr. Howden:

Q. Did you say these provinces had enough beds?—A. Yes, they have enough beds. Another interesting thing is that the death rate in Quebec and the maritime provinces does not show the same reduction. They have not had the same reduction and their death rate is greater than what it was in Ontario and Saskatchewan twenty years ago.

By Mr. Johnston:

Q. What would be the cause for that?—A. I think the reason is this: when the campaign began against tuberculosis in 1900 they had very high death rates and they have never been able to provide the same facilities that the other provinces have. For instance, we have 11,000 sanatorium beds, about one per thousand, and curiously enough that ratio holds pretty much for the two provinces. It is enough in Ontario and Saskatchewan, but in Quebec and the maritimes where they have three times the tuberculosis problem it may be only a third of what is required. I think the two important factors in the control of tuberculosis is the early diagnosis and prompt treatment. We felt for many years that we were not getting the cases early enough; they were all advanced when they came to the institutions, and it was to meet that challenge that the tuberculosis clinic was established. Clinics have been developed in other provinces. They started first to examine anybody that the general practitioners referred to them, people who had symptoms. Then they went further, they began to examine people who had been in contact with tuberculosis. Then they went further than that, they began to examine certain groups of the population; they started with school children, with normal school students, university students, teachers, nurses, and then they started on industrial groups. Then the greatest case-finding campaign we had ever had is the X-ray of the army. I do not know whether you realize it, but since the war began we have examined one in ten of the population by X-ray in that way. There are certain industrial cities where, since the war, they have examined one-third of their adult population. In Saskatchewan they have examined whole communities, cities, in the city of Moose Jaw and the city of Saskatoon they have X-rayed 80 per cent of the population. That seems to hold the key for the early diagnosis of tuberculosis because we find through this service the cases of tuberculosis that we are getting are more than 50 per cent early minimal cases, and a minimal case requires possibly only six months of sanatorium treatment; whereas a far advanced one will require eighteen months or more; so that means you can use the same bed for three patients where otherwise you would use it for only one.

By Mr. Shaw:

Q. I should like to ask the doctor if it is a fact that there is a cure for tuberculosis, let us say, of the lungs after it has reached the active stage. I understand that certain medical men say, "Yes," and other medical men say, "Definitely not." After it has reached the active stage, is there a cure, in your opinion?—A. Yes, absolutely.

Q. Then may I ask if anything has been discovered with respect to the effect of the sulpha drugs as a curative measure?—A. No. The sulpha drugs have been of no help in tuberculosis.

Q. Would it be fair for me to go beyond that point and ask as to the best type of treatment that is being provided as a curative measure?—A. The best type of treatment is sanatorium treatment, including what we know as collapse therapy; that is to say, it is possible to collapse the lung in several ways. One way is, by the introduction of air into the pleural spaces, to collapse the lung and put it at rest, just the same as you would put a broken limb in a splint.

By Mr. Howden:

Q. Pneumothorax treatment?—A. Pneumothorax. Then there are other surgical procedures. But in regard to the cure of tuberculosis, of the early cases about 70 or 80 per cent get a complete cure. We have records of thousands of cured tuberculosis patients.

Q. The only way in which you can be positively sure of a cure would be by periodic examination, say every six months, following the release of such patient from the sanatorium?—A. Yes. The first three years after discharge from the sanatorium are the important years. After seven years, discharged patients have a lower death rate than the average population. They are a select group. They know how to take care of themselves and they live longer than the average.

By the Chairman:

Q. Will you proceed, Doctor?—A. We spoke about sanatorium beds that are required. Prompt treatment, after all, depends on whether you have enough sanatorium beds and whether there is any financial barrier to treatment. We need, as I say, three beds per death. We also need to have some system of financing the cost of treatment, so that there will be no delay in the admission of patients to the sanatorium. We made a survey of the new cases that were discovered in 1940, as to how soon they got into an institution. We found what happened in the provinces where they had free treatment. In Saskatchewan, for instance, 83 per cent were admitted within a month. But in the maritime provinces where they have not free treatment only 22 per cent were admitted within a month. So there is a tremendous advantage in having free treatment.

By Mr. Howden:

Q. What are the figures for Manitoba?—A. Sixty-seven per cent.

By Mr. Lockhart:

Q. What are the figures for Ontario?—A. For Ontario, 60 per cent.

By Mrs. Casselman:

Q. For Alberta?—A. For Alberta, 67 per cent; they have free treatment there.

By Mr. Blanchette:

Q. And for Quebec?—A. Quebec, 36 per cent. I thought I should like to say something in regard to the relation of the proposed health plan to the problem of tuberculosis. For many years we have felt that there should be federal help for the problem of tuberculosis. The association is on record, year after year, in favour of federal help for tuberculosis and that was the specific recommendation that was made to the Royal Commission on Dominion-Provincial Relations in 1938. We believe that this part of the proposed plan having to do with tuberculosis—that is, giving grants in aid—is the solution to the problem. We believe that there are no difficulties of any kind in implementing it. The plans that are now in operation in the provinces are good as far as they go, but this will give us a chance to increase them, standardize them, and bring them all up to minimum standards. We believe those grants should be made under certain conditions. We think that the provinces should produce a minimum programme before they are given. We consulted the provinces on what they considered a minimum tuberculosis programme, and we submitted it to Mr. Mackenzie's committee on health insurance. As regards the size of the grant, there is a problem there. While in some of the provinces I think it is satisfactory, in others it might not be. For instance, take provinces that have a rate of, say, three times that of the others, and suppose they get only one-ninth. They would be expected to almost double their present programme and yet they would be getting only one-ninth. So that we are of the opinion that special consideration should be given to certain provinces which

have a particularly high death rate. We think that, under a nation-wide programme inaugurated under this system—since we have reduced tuberculosis 50 per cent in twenty years, even with very inadequate facilities—if we had adequate facilities, we could reduce tuberculosis to a very minor cause of death in twenty years.

The CHAIRMAN: Does that answer your question, Mr. Shaw?

Mr. SHAW: Yes. I just wanted to ask one other and it will take only a moment. I think perhaps this should be directed to the minister. Is it true that persons accepting employment, let us say, in government offices, are obliged to take a medical examination before accepting such employment? If so, is this being rigidly enforced, if it is supposed to be a regulation?

Dr. HEAGERTY: Before the war there was no compulsory examination for a temporary employee, but at the time he was made permanent he was obliged to undergo an examination. But, since the war, I understand that every one coming into the service undergoes an examination.

By Mr. Donnelly:

Q. May I ask what the cost per day is for hospitalization?—A. It would average about \$2.50.

Mr. HOWDEN: While Dr. Heagerty is on that point, I should like to ask a question. Do these examinations which you are talking about include X-ray of the chest?

Dr. HEAGERTY: No. That is one of the unfortunate things. We do not have X-ray examination of the chest. Only yesterday Dr. Douglas came to my office with a report of a young woman from the Bureau of Statistics who had come in for examination. He was able to detect tuberculosis without an X-ray, but it was so far advanced that he had to instruct her not to return to her employment. He arranged with the province of Ontario to provide her with free treatment in a sanatorium. That is one of the great difficulties that we have to contend with. We cannot detect tuberculosis early among civil servants because of the lack of X-ray apparatus.

By Mr. Howden:

Q. In other words, the former methods of diagnosis were unreliable, as far as tuberculosis is concerned, or were very largely unreliable?—A. Yes, very largely.

Mr. MACINNIS: What effect would it have on an employee's standing for employment, if the health standard is not what is required?

Dr. HEAGERTY: Some years ago I used to do these examinations myself, and I used my own judgment in the matter. I found that very often young people coming up for examination suffered from albuminuria; some of them had heart conditions. I took into consideration the nature of their employment. If I was of the opinion that the condition did not affect their work or their longevity, I approved of their engagement as civil servants. I found after some time that that was exactly the procedure that was followed by the British Post Office authorities. They do not refuse employment to all of those who suffer from conditions that will not likely affect their employment or shorten their lives.

Mr. MCGREGOR: I have a question about this examination. Before a person can get into the civil service, must he be physically fit?

Dr. HEAGERTY: As I indicated, physically fit for the nature of his employment. There is no hard and fast rule. We state on the form whether or not the individual is capable of carrying out ordinary duties or heavy duties—heavy work.

By Mr. Shaw:

Q. Is it true, Doctor Wherrett, that one of the great difficulties you are confronted with now is that you cannot oblige a person who has been sent to a sanatorium to remain there? I have heard of cases where a person has been sent to a sanatorium, but who maybe became lonesome, homesick or something, and came back into the community. Would there not have to be an element of compulsion for any successful scheme of prevention or cure?—A. Well, that is a problem. I feel that if you provide enough beds, and you make treatment free, you will be able to keep most of the patients in sanatoria as long as is required. As a matter of fact, there is some compulsion. Some provinces, under the Health Act, have authority to admit patients. But we have found that public enlightenment, public information and persuasion is better than compulsion, if you can get away with it.

Q. Yes, that is true.

By Mr. Johnston:

Q. I should like to ask the Doctor a question at this point. He has indicated the figure for tuberculosis. I wonder if there has been any examination as to what is known as Sherman's disease. My information is that that is a forerunner of tuberculosis. I am also informed by medical authorities that, in the last six months, there has been a great number of cases of Sherman's disease reported. Would the Doctor elaborate on that point?—A. I do not know anything about Sherman's disease.

Q. My information is that it is a forerunner of tuberculosis.—A. There is no forerunner of tuberculosis. There are certain conditions that make it easier for the tubercle bacillus to work. For instance, silicosis patients or employees who have silicosis are more likely than others to develop tuberculosis.

Q. The reason I asked that question is that when I was in Calgary not long ago I was talking to some of the doctors in the clinic there. They said that in the last six months there had been, if I remember rightly, about fifteen to twenty cases of Sherman's diseases. My information is that that is a sort of forerunner to tuberculosis.

By Mr. Bruce:

Q. Referring to the question raised by one of the other members of the committee as to compulsion to remove a patient into a sanatorium and keep him there, I was not quite clear about the matter. I understood the witness to say that there was no compulsion in any province.—A. No. There is compulsion. In a number of the provinces they have authority not only to admit them but to keep them. In Ontario, for instance, they have that authority.

Q. That is, there is authority to send them there?—A. To send them there and keep them there.

Q. It is a communicable disease, and it should be treated the same as any other communicable disease. In other words, if a patient is allowed to remain at home where there is a family of several other children, there is no question about the fact that the others will be infected. It is only, I understand, in Ontario that they have authority to take them out of the family and send them to the sanatorium.—A. They have authority in most provinces under the Health Act to do that.

Q. They have authority?—A. Yes. But the point I was trying to make was that persuasion was usually sufficient.

Q. While I am speaking I just want to raise another question, referring to something said by Dr. Heagerty, in regard to the desirability of having X-ray plates taken of any person who is being admitted into the civil service. I take it that is not done. Does he think it should be done?

Dr. HEAGERTY: I think it would be advisable and extremely helpful; very advantageous.

Mr. WOOD: Why confine it to the civil service?

Dr. HEAGERTY: We have no jurisdiction over other than the civil service.

Mr. KINLEY: Mr. Chairman, what is this Sherman's disease?

The CHAIRMAN: We are not discussing that.

Mr. KINLEY: I know.

The CHAIRMAN: We are not discussing Sherman's disease.

Mr. KINLEY: Yes, Mr. Chairman, we are.

The CHAIRMAN: We are answering a question asked by Mr. Shaw with regard to tuberculosis. The question has been answered.

Mr. KINLEY: Pardon me, Mr. Chairman; this Sherman's disease is incidental to that.

The CHAIRMAN: Mr. Shaw made no reference to it.

Mr. KINLEY: Because it is a predisposition, because it is a forerunner of tuberculosis. I asked a simple question; what is Sherman's disease?

The CHAIRMAN: Dr. Wherrett answered that he does not know.

Mr. KINLEY: Oh, I see.

Mr. SHAW: At some later deliberation would it be possible for us to discuss this question further?

The CHAIRMAN: Certainly.

Mr. WOOD: Before the doctor retires, I was rather interested in the answer he gave in respect to the degree of prevalency with respect to tuberculosis among the Indians. Is that not a great source of infection; because, after all, they circulate quite freely among the white population.

The WITNESS: We believe that the Indians spread the infection not only amongst themselves but amongst the white population, and in 1937 the Indian Affairs branch did undertake a programme for the control of tuberculosis. To give you an idea of the progress they have made, they had about fifty cases in the sanitarium in 1937, and just the other day they told me they had 800 in institutions. That will give you an idea of the progress they are making. We think there ought to be just twice as many patients in sanatoria from what we know of the amount of tuberculosis among Indians.

Mr. DONNELLY: Is gland disease and bone disease as prevalent among the Indians as it was?

The WITNESS: No, it is not, Dr. Donnelly; it is not nearly so prevalent as it was twenty years ago.

Mr. FULFORD: I hold in my hand a series of statistical reports—

The CHAIRMAN: It is obvious.

Mr. FULFORD: What is that?

The CHAIRMAN: I said, that is obvious.

Mr. FULFORD: —prepared by the province of Ontario. And now, whether the other provinces have gone into this as thoroughly as Ontario has or not, I do not know; but I would advise every member of this committee to obtain at least one of these, and that is tuberculosis prevention as an economic factor in the province of Ontario, with statistical tables and graphs. It gives one a visual picture of how tuberculosis has decreased in direct relation to the sanatoria that have been built. Take just one section of the province—take the counties of eastern Ontario which in 1931 were pretty bad, generally speaking—the death rate was between sixty and seventy in that section—that has been decreased in most of the counties, if not in all—in most of the counties to between twenty and twenty-nine in ten years. I cannot recommend too highly the committee

studying these tables and charts because they show beyond all shadow of doubt what can be done with tuberculosis when it is properly handled.

The CHAIRMAN: Thank you. Where are they obtainable?

Mr. FULFORD: From the Parliament Buildings, Toronto. I would be very glad to table these.

The CHAIRMAN: Thank you.

Mr. McCANN: I want to ask the minister a question in view of health insurance coming into effect in Canada. We have been hearing quite a lot about tuberculosis among the Indians; would it be applicable to the Indian population? The reason I ask that question is this: probably it gives the answers to some of the causes of the prevalence of tuberculosis among the Indian population—and, of course, it is well known that the government of this country has both moral and contractual obligations with respect to the Indian population with reference to their education and with reference to the maintenance of their health. Now, at the present time Indians are looked after by the medical department or medical subdivisions of the Department of Indian Affairs. They do not come under the Department of Pensions and National Health on the health end of it apparently, nor do they come under the provincial departments of health in which these Indian reserves are located. And now, I submit to this committee that one of the reasons why we have a high death rate among Indians is the divided authorities which we have with reference to looking after them. However, if we put health insurance into effect and they can be brought into that scheme then their medical attention and hospitalization would come under the commission or the department; at least, I suggest that it should come under the department in the province or under the commission which will be operating the health insurance scheme. Indians are very prone to tuberculosis as a race, and if we carried out our obligations to them in the manner in which we should, there is no reason why the death rate both as to mortality and morbidity in regard to tuberculosis among them should not be down about equal to what we show with respect to the white population. But it should be recognized that we suffer by reason of the times; with easy transportation and easy communcination with other communities with the result that the Indian population are not isolated as they should be, or as they used to be, and they come in contact with the white population in the adjacent cities and towns and other communities. They get into industrial employment, although they live on their own reservations, and they come into actual contact with a great number of the population, and in that way they are communicating the disease to the white people. And now, of course, you cannot exclude them from these communities. Not being in a position to exclude them, then the white population other than the medical department of the Department of Indian Affairs should take a very active interest in their medical problems, particularly with the tuberculosis problem; and I suggest that it would be an excellent move if they are not to come under the health insurance scheme, that the medical care of Indians be transferred from the Department of Indian Affairs to the Department of Pensions and National Health.

Some Hon. MEMBERS: Hear, hear.

Mr. LOCKHART: May I just supplement what Dr. McCann has said, just in the way of a suggestion, and point out to Dr. Heagerty—perhaps he will find a medium through which this idea could be given effect—that in places like the part of the country from which I come, a great fruit-producing area, a great number of Indian families have moved down holus-bolus for the entire season, and they bring their wives and children with them. The danger there is, as I see it, that they come into these communities and spread this disease

among the white people. I was wondering if something could not be done in respect of controlling movements of that kind. I just pass that on as a suggestion.

The CHAIRMAN: Dr. Heagerty will comment, please.

Dr. HEAGERTY: With regard to the question just raised, it is quite clear that all Indians working outside of the reserve will automatically come under the heading of the health insurance scheme, but special provision will have to be made for those on reserves, if it is the desire of the dominion government that they should be provided with health insurance.

Mr. HOWDEN: I do not believe any great headway will be made with regard to the Indian problem, certainly not in the northern district, until the environment is materially changed. I have had to face conditions. I had considerable experience with the Department of Indian Affairs. I was out on the Indian treaty in the summer of 1907, and I know something about tuberculosis conditions among Indians who live in that north country; I know that when I was up there on the Indian treaty they were dying of tuberculosis in groups—not one or two but by the half dozens and the dozens—and one of the things that had a great deal to do with the spread of tuberculosis among the Indians as I saw it on that trip was the conditions under which they live. They live in little mud-covered huts, ten feet by twelve feet, with as many as ten or twelve persons living in that one overcrowded hut. Then, I think there is one thing we need to recognize, and that is that when the Indians lived in their natural state in their tepees, and they were free to roam where they would, their general health condition was excellent; but since they have been crowded into these little huts that are the result of our modern civilization the spread of tuberculosis has been terrific. I believe the first step any government will have to take to better conditions for the Indians in respect to health must be through the improvement of living conditions for the Indians. I do not think there is any question about that at all.

The CHAIRMAN: Dr. Heagerty will be available for further discussion.

We have the privilege this morning of hearing from representatives of the Canadian Hospital Council. Mr. George S. Stephens, president of the council, will introduce the representatives. Dr. Stephens, please.

Dr. GEORGE S. STEPHENS, Montreal, *called*.

The WITNESS: Mr. Chairman, Mr. Minister, ladies and gentlemen: the privilege is the other way; we are privileged to be allowed to present our case before your select committee. We have the executive council here; at least, a committee representing the council. The council, as you may possibly know or possibly you may not know, is simply a federation of all the hospital associations in Canada; provincial, and regional—it takes in Sister organizations, who are also members although they have their Catholic Hospital Council as well.

We have been fortunate in these health discussions in seeing the drafts, or discussing them, with Dr. Heagerty; and, subsequently, with his committee, from the outset. We have submitted our principles and our views to his committee, and many of them have been accepted; so that the arrangement has been most harmonious. With me to-day are the Reverend Father Brennan, Dr. Harvey Agnew, Mr. J. H. Roy—of the council; but we have no representatives from the maritimes, the prairies or British Columbia. We have also here, as a member of the council but not of this committee, Reverend Mother Allaire representing the Catholic Hospital Council; and I think Rev. Father Boubier of Laval is here also. He was to come.

With your permission I will ask Dr. Harvey Agnew, secretary of the council, who is to my mind the outstanding hospital authority in Canada and is thoroughly familiar with the American situation as well, if he would present this brief. Would that be in order, Mr. Chairman?

The CHAIRMAN: Yes.

Dr. HARVEY AGNEW, *called*.

The WITNESS: Mr. Chairman, Hon. Mr. Mackenzie, Mrs. Casselman, and gentlemen:—

The Canadian Hospital Council appreciates very much this opportunity of appearing before the Special Committee on Social Security of the House of Commons. As hospitals exist primarily to restore our people to health and as their work will be vitally affected by whatever plan be adopted for caring for the sick, it is but natural that they should be deeply concerned with proposed legislative changes.

THE CANADIAN HOSPITAL COUNCIL

The Canadian Hospital Council is a federation of the provincial, inter-provincial and regional hospital associations in Canada—twelve in all. In addition to the provincial associations and the Maritime Hospital Association, the membership includes the regional “conferences” of the Catholic Hospital Association of the United States and Canada. In Quebec where there is no provincial hospital association, the hospitals are represented by the Montreal Hospital Council, and the Montreal and the Quebec Conferences of the Catholic Hospital Association. The Department of Hospital Service of the Canadian Medical Association is a member, as is also the Department of Pensions and National Health and the provincial Departments of Health of all of the provincial governments. These governmental departments are what might be termed “associate members” and are not necessarily party to this submission. A close co-operation between governments and hospitals was considered advisable but, as policies adopted might prove embarrassing to departmental representatives, they, at their own request, were designated as non-voting members.

From this statement it will be seen that the Canadian Hospital Council represents the individual hospitals through their respective hospital associations and conferences. With but a few exceptions, practically all of the voluntary and municipal hospitals and the tuberculosis sanatoria belong to these associations and conferences.

THE HOSPITAL SYSTEM OF CANADA

The hospital system of Canada can hardly be described as being of any one type. The first hospital in either Canada or the United States, the Hotel Dieu of Quebec, which was opened over three hundred years ago (1639), was operated by a religious order, as were also practically all hospitals founded for some time afterward. Later, the lay voluntary non-profit community hospitals increased until they became the more numerous group. In more recent years the municipal, civic, or “union” type of hospital has shown great increase, particularly in the prairie provinces.

Then I would like to give you some statistics furnished to us by Mr. Brady of the Dominion Bureau of Statistics. I will not read them through.

According to the latest figures available at the Dominion Bureau of Statistics, the comparative figures for 1941 of the different types of hospitals are as follows:—

HOSPITALS IN CANADA, 1941

	Hospitals	Adult beds and cribs	Bassinets
Acute Diseases ¹	573	46,504	5,980
Tuberculosis	43	10,992 ²	....
Chronic and Insurable.....	20	3,415	....
Contagious Diseases.....	14	1,713	5
Convalescent (public).....	10	830	....
Mental	60	40,115 ³	....
Private	325	3,867	776
Dominion ⁴	175	9,493	6
Totals.....	1,220	119,019	6,766

¹ Includes general, women's, children's, Red Cross and not classified.

² Includes 2,090 beds in 37 tuberculosis units of acute diseases hospitals.

³ Includes 785 beds in two dominion hospitals.

⁴ Last figures available as on September 24, 1940.

CONTROLLING BODIES OF HOSPITALS IN CANADA, 1941

	Hospitals	Adult beds and cribs	Bassinets
A. Acute and Chronic (other than tuberculosis)—			
VOLUNTARY ¹			
Lay	215	20,106	2,478
Roman Catholic.....	181	21,886	1,593
Red Cross and Junior Red Cross.....	44	590	160
United Church.....	19	546	103
Salvation Army.....	11	688	295
Anglican Church.....	6	211	19
Other	17	733	92
MUNICIPAL (including union).....	120	8,842	1,213
PROVINCIAL	4	950	31
DOMINION	175	9,493	6
PRIVATE (including industrial).....	325	3,867	776
Totals.....	1,117	67,912	6,766
B. Tuberculosis Sanatoria.....			
Lay	43	8,902	....
Roman Catholic.....	24	5,887	....
Provincial	5	754	....
Municipal	6	1,358	....
Dominion ²	4	656	....
T.B. units in Acute Diseases hospitals ³ ...	4	247	....
	37	2,090	....

¹ Includes children's, general, women's, contagious diseases, convalescent, Red Cross, incurable and not classified.

² Includes one sanatorium opened in 1942.

³ These figures are included in acute diseases hospitals.

I would just like to comment on certain ones that are here. You will note for instance, that under acute diseases we have 46,000 beds, which is a very commendable figure for a young country like Canada. We have nearly 11,000 tuberculosis beds and yet when we come down to convalescent care we are down to 830. The totals are interesting. There are 1,220 hospitals altogether with 119,000 beds, and with bassinets that brings the figure up to about 126,000. On the following page we have the controlling bodies of hospitals. Again you will note that the lay group with 215 hospitals have the largest group. However, the

hospitals operated by Sisters, while not quite so numerous, actually have a greater number of beds, 21,886. These different voluntary hospitals altogether make up 493, or a total of over 44,000 beds, whereas you will note that municipal hospitals which are growing in number, 120 with 8,842 beds, are still a comparatively small number.

From these figures it will be seen that the hospital system is a combination of several types. It would seem correct, however, to consider the system as being mainly of the voluntary non-profit type, lay and religious.

It would be fitting at this stage to make some appraisal of our present hospital system.

APPRAISAL OF PRESENT HOSPITAL SYSTEM

The hospital system developed in Canada has its good points and its weak ones. On the whole, however, we feel that Canadians can be intensely proud of their hospitals, which are easily the equal, class for class, of those found anywhere else in the world and are far in advance of those found in many countries.

POINTS OF EXCELLENCE

1. *Widespread hospital coverage*

Considering the vast area of Canada and its scattered population, our hospital coverage is indeed excellent. Small hospitals are dotted across the country wherever there are settlements large enough to support a hospital. Some 54 per cent of our public general hospitals are of 50 beds or less in size. Some 25 per cent are of 25 beds or less capacity. The small hospital movement received considerable stimulus after the First World War, when many communities, particularly in the central and eastern provinces and in British Columbia, erected "memorial" hospitals. Later the civic or municipal hospital movement spread from the larger centres to the rural areas particularly in the prairie provinces, where "union hospitals" became popular in rural municipalities. Many rural areas which do not have public hospitals are served by small "private", or proprietary, hospitals.

In many areas unable to finance their own hospitals, the Canadian Red Cross Society has been extremely helpful, building and operating these small hospitals until such time as the community can take over the responsibility. There are now 44 Red Cross outpost hospitals scattered from Grand Manan island on the Atlantic to Kyuquot in British Columbia.

2. *The hospitals take good care of the poor*

Those who cannot pay for their own hospital care—the so-called "indigent"—receive excellent hospital care. Our public hospitals accept patients irrespective of financial status, race, religion or colour.

3. *Provincial grants and municipal payments are of great assistance*

The system here of municipal payments for residents unable to pay and of provincial per diem grants for patients in certain categories (public ward in some provinces; all patients in other provinces), is unique to this country. Only a few of the United States of America have this arrangement and few other systems are at all similar. The payments are usually short of the actual cost of care but do make it possible for hospitals to give "public patients" the fine care now given. Not only is this possible, but in many young municipalities with limited financial resources citizens have been encouraged to set up a local hospital—I mean a voluntary hospital—knowing that a substantial share of the cost of caring for non-pay patients would be forthcoming. This assistance to voluntary effort is of particular value because of the fact that very few hospitals have substantial endowments.

4. *Our hospitals are predominantly "public" ones; only a few are proprietary*

Some 67 per cent of our hospitals for acute and chronic diseases (other than mental and federal) are "public" hospitals, i.e., they are non-profit hospitals (voluntary or municipal) which have been approved by their respective provincial governments for the receipt of provincial and municipal assistance in caring for those unable to pay their way*. Actually the proportion of beds in public hospitals is much higher, for 94 per cent of the beds for these conditions are in public hospitals. This means a greater provision for those patients who either cannot pay or can pay but a part of the charges. It also implies a greater degree of control and supervision by the provincial Department of Health.

5. *Service is maintained at a high level of quality*

There are several factors all helping to maintain hospital service at a high level:

- (a) Provincial supervision and control;
- (b) The "standardization" programme of the American College of Surgeons has been largely instrumental in organizing the medical work of hospitals on the present effective basis;
- (c) In approving hospitals for the training of interns the Canadian Medical Association has raised considerably the quality of service to the patient;
- (d) The approval of schools of nursing by the provincial nurses' association (in some instances with the co-operation of the provincial government) has done much to raise the standard of hospital nursing.

6. *Public and private patients are in the same hospital*

All non-profit hospitals, voluntary or municipal, care for both public ward and private patients, usually in the same building. There are no "county" hospitals for free patients as in large centres in the United States and no segregation of private patients into private nursing homes as in Great Britain.

I should add that a number of British voluntary hospitals have added private beds to their accommodation in the last few years.

This is a tremendous advantage to all parties concerned. The greater number of patients means better facilities, including expert staff, for diagnosis and treatment. Costs are reduced, the time of the medical staff is conserved, the "atmosphere" of the public services is improved and the whole arrangement is more democratic.

PRESENT WEAKNESSES

1. *Costs are severe handicap to patient of moderate means*

The costs of hospitalization are a severe strain upon the family with a moderate income. Life savings are frequently wiped out by a serious or protracted illness. It is not that the total charges for hospitalization are high; the public pay directly but approximately \$22,000,000 to \$30,000,000 for their hospitalization, depending upon the cycle of prosperity. Such figures constitute but a fraction of that paid for tobacco, for liquor, for cosmetics, or on betting—but the trouble is that illness hits without warning, people seldom budget for it, and the expense comes as a formidable item at a time when it is most difficult to meet extra payments.

* In the United States, public hospitals are municipal or governmental ones only. Voluntary hospitals are frequently termed "private" hospitals. What we term "private" hospitals are called "proprietary" across the border.

Hospital charges are remarkably low in view of the miraculous results obtained. Charges to paying patients could be still lower if public funds provided for the care of non-paying patients were sufficient to meet the actual costs.

Voluntary hospitalization plans and the hospitalization plans of insurance companies have been of much assistance to patients of limited income. One non-profit group hospitalization scheme, the plan for hospital care in Ontario, has attained a membership of 175,000 in approximately two years. A number of excellent voluntary plans are operating from coast to coast—some providing hospitalization and some combining allowances with medical care. These plans do lessen the economic burden of hospitalization but, unfortunately, they do not fully cover the country, particularly the rural areas.

2. Some rural communities lack hospital facilities

Earlier it was stated that coverage in Canada is excellent because of a large number of small hospitals strategically placed from coast to coast. It is true, however, that quite a few rural communities do lack hospital facilities. In many of these areas hospitals are needed, particularly in bad weather.

This need may not be as great as would appear. With motor cars, good roads, rural telephones and, in some cases, the aeroplane, distance is a much less important factor than it was a generation ago. Moreover it is being realized that one well equipped and staffed hospital in an area is infinitely better than two or more smaller hospitals in adjacent towns without x-ray, laboratory or other special facilities and with very limited, if any, technical staff.

3. Lack of coordinated planning results in gaps and duplication

The history of hospitals, in this as in most other countries, has been one of individual rather than of coordinated planning. Most hospitals owe their origin and their continued operation to a few public-spirited men and women. Because of this dependence, some communities lack hospital facilities, while in others there may be unnecessary duplication. In some communities there is a surplus of beds for private use and a shortage of public beds; in others there is a lack of facilities for isolation, or for the care of convalescent or chronic patients.

4. Present system of paying for indigents is a frequent cause of strained relations between hospitals and municipalities

Most provinces have enactments requiring municipalities to pay a stipulated per diem rate for their residents who cannot pay for their hospitalization. Despite many revisions these arrangements cause endless controversy over "residency", "indigency" and the general question of how much should be considered a fair per diem payment. For many patients—transients and others—the hospitals receive no municipal assistance. Few municipalities pay for out-patient care.

Trustees of hospitals, giving freely of their time, their thought and of their substance on behalf of the sick, become discouraged over these controversies and would welcome an arrangement which would eliminate these sources of friction and anxiety.

Then the remainder of the memorandum deals specifically with health insurance.

HEALTH INSURANCE

The Canadian Hospital Council is generally in favour of the principle of health insurance. This is not necessarily the opinion of individual boards of trustees or Sisters' councils, nor of the governmental departments cooperating in the work of the Canadian Hospital Council. Nor does it imply approval of any particular plan.

It is agreed that the financial burden of sickness to the average patient is such that some measure should be adopted to relieve him of this burden, coming as it often does when lack of income makes the burden particularly difficult, and to spread this cost among those who are healthy and better able to meet the obligation.

ESSENTIAL PRINCIPLES

It is most desirable, however, that any measure of health insurance introduced should preserve the best in our present system of hospital care. It should be possible to retain what is worthy of preservation and overcome serious weakness or omissions in our hospital facilities without too radical revisions in our basic system.

1. *Voluntary hospitals should be utilized*

Particularly desirable is it to preserve the principle of voluntary support. Nearly two hundred millions of dollars have been spent in the construction of voluntary hospitals, lay and religious, in this country and the amount of effort put forth in their operation by countless volunteers can never be computed. Our effort should be, not to destroy voluntary effort and replace it by the more impersonal state support, but to bring about a cooperative effort in which the individual would be encouraged to supplement the aid and support provided by society as a whole.

To this end it is desirable to continue to utilize existing voluntary hospitals, provided they conform to the standards of service stipulated by the commission or other directing body.

This would imply that patients should have the right of selection of hospital, provided the hospital conforms to the standards stipulated, as stated above, and provided also that the patient comes within the categories of illness accepted by that hospital.

2. *Hospitalization should be through "public" hospitals*

Except by special arrangement, the hospitals eligible to receive payment for service to insurance patients should be those recognized by the provincial governments as "public" hospitals, i.e., either non-profit voluntary hospitals (lay or religious) or municipally-owned hospitals.

Exceptions to this might be in those instances where extensive rural areas are served by proprietary hospitals only.

3. *Hospital benefits should be reasonably complete*

Hospital benefits should include:

- (a) General ward care;
- (b) Necessary drugs, dressings and appliances;
- (c) Operating room and case room charges;
- (d) Necessary diagnostic procedures;
- (e) Physiotherapy and occupational therapy, where deemed necessary;
- (f) Special nursing, only where such is definitely essential;
- (g) Such other hospital provisions as are approved by the controlling body.

4. *Facilities should be made available for all types of patients*

At the present time there are insufficient facilities for many types of illnesses. There is a serious lack in most provinces of adequate provision for patients suffering from chronic or incurable diseases. There is also a lack of convalescent facilities, the provision of which would release beds in more expensively-equipped general hospitals and would hasten the return of patients to gainful employment.

In most provinces there is also a lack of adequate accommodation for patients suffering from tuberculosis and for those suffering from mental disorders. There is a serious lack, except in a few centres, of observation wards for those suffering from mild mental symptoms possibly due to other conditions. There is inadequate accommodation, too, except in large centres, for patients requiring isolation. There is also a serious lack of facilities for the treatment of alcoholics and narcotic addicts. While homes for the aged and the infirm can hardly be considered as hospitals, their lack is a serious problem everywhere and does increase the strain upon our general hospitals.

To meet these needs, it would seem necessary that voluntary effort be supplemented by state assistance.

5. Hospitalization of "ingredients", or those unable to pay, should be provided for under the plan

It is most desirable that any plan of health insurance should cover those who are unable to pay as well as those who make contributions. These patients should receive the same hospital benefits as do other members of the plan. If payment be adequate to meet cost, as it should be, this would render unnecessary the present system of municipal payments and provincial grants.

6. Dependents of the insured should be included

Not only the breadwinner but all dependents should be included in plan of health insurance. It would promote national welfare to include all children, irrespective of number, without further premium charge to the parents.

7. Remuneration of hospitals should be adequate

As our hospitals, with a very few exceptions, have no endowment and are dependent for their operational expenses upon payments from various sources for services rendered, it is essential that the hospitals receive adequate remuneration from the insurance fund:

- (a) to ensure efficient treatment of patients, commensurate with present day standards;
- (b) to meet actual cost of providing hospitalization;
- (c) to provide reasonable allowance for depreciation and expansion of essential facilities;
- (d) to permit desirable teaching and educational work.

8. Basis of remuneration should be fair to all parties concerned

A basis of remuneration should be worked out which would be fair both to the individual hospital and to the fund. The facts should be recognized that costs of operation vary and are particularly affected by the provision of costly equipment, specialized departments, the employment of expert personnel and, in the case of some small hospitals, by intermittent patronage or the cost of bringing in supplies.

As alternative methods of payment might be considered, it is recommended that, in each province, the basis of payment be worked out in consultation with representatives of the hospitals.

9. Hospitals should retain the right to determine their own staffing privileges

At the present time the law expects hospitals to exercise due care and judgment in the selection of their medical staffs. This is based upon the assumption that, in contributing to the care of ward patients, the state has a right to expect that such patients will receive competent care. This selection is usually done by the hospital governors or trustees upon the recommendation of the credentials, or equivalent, committee of the medical staff. It is very helpful to a

physician to have hospital privileges and most doctors now have such, within their field of activity or competence, on some hospital staff. For some doctors it is a courtesy privilege for private patients only; for others the privilege is one of providing gratuitous service to public, or indigent, patients. Health insurance may materially alter the picture. However, as hospitals have a responsibility to their patients and take justifiable pride in the reputations which they have been able to build up, they are very anxious that no development occur which would permit other interests to force them to extend highly technical privileges to doctors whom the trustees, on the advice of their medical staffs, do not feel should be admitted to the staff nor given such privileges. Should this protection to the hospitals and their patients be withdrawn, it would be exceedingly difficult to retain the interest and enthusiasm of the many altruistic men and women now serving on hospital boards and in other capacities.

10. *Insured persons should have the privilege of taking higher priced accommodation by paying the difference in charges*

It is presumed that under the proposed plan a standard type of hospital accommodation will be provided; this would probably be of a public ward nature. If patients desire to take semi-private or private accommodation or to have special services not provided under the plan, such should be made possible upon payment by the individual of the difference in charges.

11. *Health insurance should be on a provincial basis but under federal co-ordination*

It would seem advisable in the beginning to have health insurance introduced on a provincial basis, but so influenced by a federal enabling act providing certain financial assistance under stipulated conditions that ultimately it might be possible to unite all provincial plans in a common nationwide plan.

This procedure is recommended for the following reasons:

- (a) Conditions vary so widely in different provinces that it would be much more difficult to set up a workable plan on a national basis than on a provincial basis;
- (b) As accurate data respecting likely morbidity, costs, etc., based upon Canadian experience, are difficult to obtain, some subsequent revision in costs may be anticipated; should initial experience indicate inadequate budgeting and an operational deficit ensue, it would seem better to have such upon a small scale provincial basis rather than upon a much more extensive national basis;
- (c) A national plan administered federally would probably require B.N.A. Act amendments.

12. *Direction of the Plan should be strictly non-political*

Because of the vital importance of the health of our people to the national welfare, it is most desirable that the direction of the plan be kept strictly non-political. It is our majority opinion that, in the provinces, the administration should be through an independent, non-political commission, answerable to the Lieutenant-Governor in Council, either directly or through the Ministry of Health. Alternatively, the plan might be operated under the Minister of Health, provided the different bodies representing those rendering the services be given a reasonable voice in the control and supervision of these services.

13. *Hospital representation on the Commission or Advisory Council*

The commission, whether large or small, should be broadly representative of the various groups concerned, both those receiving the services and those rendering them. While the appointment of a hospital representative would not

be expected should the commission be quite a small one, it would be expected, should the commission be large and in view of the importance of hospital services under any health insurance plan, that the hospitals should have their own representative on such commission.

It is presumed that there will be set up a general advisory council or board to advise the commission (or Department of Health) with respect to the operation of the measure. On such council or board the official hospital organization, provincial or national as the case may be, should be represented.

As part of the federal organization to administer the proposed enabling legislation an advisory council or board is recommended. On such body the Canadian Hospital Council should be represented.

14. *The health insurance fund should be a contributory one*

It is highly desirable that health insurance should be on a contributory basis. Although the individuals comprising society must pay the entire cost in the final analysis, it is desirable that the individual citizen have a feeling of personal responsibility in keeping the operational costs to a reasonable level.

In our opinion, the health insurance fund should be supported by contributions from (a) the insured; (b) the employers; (c) the federal government; and (d) the provincial government.

GENERAL RECOMMENDATIONS

15. *Preventive medicine a major feature*

Preventive medicine is so vital to the welfare of the nation that this should be a major provision of any legislation adopted. Any public funds expended on public health or on preventive procedures generally should yield dividends in better health and greater national prosperity and happiness far outweighing any factor of cost. To this end there should be close cooperation and coordination of effort between the federal and provincial directing bodies and the federal and provincial departments of health.

16. *Research*

Under any plan there should be adequate provision for the conduct of scientific research. Scientific medicine is not static; our improved health to-day is largely due to the researches of those who have gone before. Moreover we have profited in this country from the researches conducted and financed in other countries. It is only fair, therefore, that we in Canada should take active steps to continue and augment our own contribution to scientific advancement.

17. *Teaching hospitals*

It is very important that clinical teaching in medical schools be maintained. Medical education is a combination of academic instruction and clinical, or bedside, observation. There is a distinct possibility, unless safeguards be instituted, that clinical teaching may be impaired, inasmuch as it is anticipated that all individuals, whether able to contribute or not, will be included in the plan. With diminished opportunities for clinical observation, medical education in Canada would fall to a lower standard, and this would be of serious consequence to the health of the next generation. The necessary provisions should be made in the provincial regulations.

18. *Voluntary hospital and medical care plans should be encouraged for those above the income level (if any)*

Should it develop that there would be an income level below which participation in a health insurance plan would be obligatory and above which participation would not be possible, there would be a large group of individuals

and families for whom these health benefits would not be available. To meet the needs of these persons, should an upper income level be named, it is recommended that encouragement be given to the utilization of province-wide, voluntary, non-profit plans for the provision of hospital and other health care. Where possible, existing plans might be modified to meet the altered conditions and they and their personnel utilized for this purpose, provided they conform to reasonable standards.

19. *Cash benefits*

It is realized that under any broad plan of health insurance, or of social security, cash benefits in case of illness would be of value to the family involved. At the present time unemployment insurance benefits are not available as long as the workman is not fit to return to work. The provision of cash benefits, however, complicates the medical and hospital picture very much, inasmuch as there has been a tendency under Workmen's Compensation and other plans for some individuals to seek a longer period of convalescence than is absolutely necessary. This has created difficulties for the conscientious doctor and for the hospital.

If cash benefits be considered necessary, as may be the case, it is recommended that such be paid from a fund separate and apart from the health insurance fund.

20. *Divulgence of clinical data*

With the introduction of general health insurance it is obvious that fairly extensive reports on patients may be required. This brings up the question of the extent to which hospitals, doctors and nurses are justified in revealing information generally regarded as of a confidential nature. A medico-legal point is here involved. Before any measure be put into operation it is highly desirable that the position of the hospital and its personnel with respect to the divulgence of clinical data be clearly set forth.

Further Recommendations at a later date

It is quite possible, as the draft measure is studied in further detail and as developments occur in the discussion by and with the special committee, that the representatives of the hospitals may desire further opportunity to discuss certain details respecting hospitalization.

CONCLUSION

In conclusion, the Canadian Hospital Council, on behalf of the hospitals of this country, wishes to record its desire and willingness to be of any service possible in the working out of any plan of health care which will be of lasting benefit to the sick and will promote better national health.

The CHAIRMAN: Are there any questions?

Mr. HOWDEN: I would like to congratulate Dr. Agnew on his very excellent submission to this committee. It has been very helpful indeed, and very constructive; but there are a number of points that will require to be cleared up. I am going to refer to the one which he has just passed over, his paragraph No. 20, Divulgence of Clinical Data. I realize that is a very deep subject, and I was wondering if, in the first case, that applied to hospitals; because, it is a well known practice that if a doctor has a patient come into his hands he will look up the case history. At the present time they have the privilege of looking up the case histories so as to get any data as to the former condition of their patient.

The CHAIRMAN: I will ask Dr. Stephens to answer that.

Dr. STEPHENS: I think this refers more particularly to information that would be required by national health insurance officials, as to its being in lay hands. Presumably there will be some forms required, medical reports, which will have to go out; and it should be clarified. As to the information given by hospitals, I do not think it refers to the ordinary relation between doctor and patient.

Mr. FULFORD: Dr. Agnew has stated that where the hospital plan has been adopted the results have gone far beyond the wildest expectations. The reason I mention that is that the hospital plan is in essence a forerunner in a very modified form of health insurance; and it is a community undertaking. I have in mind at the moment the community which I happen to know very well, the town of Brockville; and in both our Protestant and Catholic hospitals the results have been nothing short of phenomenal.

Dr. AGNEW: Dr. Stephens and I are vitally interested in these voluntary plans. Dr. Stephens had a great deal to do with the start of the Manitoba plan, and I happen to be the director of the Ontario plan about which you spoke. These plans have done a very excellent service to the people on this continent—the different plans that have measured up to standard requirements—they are known as Blue Cross plans and are operating about seventy-five across the United States and Canada. They serve about 11,000,000 people, and they have done a great deal to mitigate the cause of sickness for their members. The difficulty, however, is to get the coverage for the whole population. They are on a voluntary basis, and for that reason some of us who are very much concerned over the possibility of the absorption of these plans into a larger plan feel that such may be inevitable if it be set by our legislators that we should have some plan that would bring in everybody.

Hon. Mr. MACKENZIE: Do these plans include the Indians?

Dr. AGNEW: No, they do not include the Indians?

Mr. McCANN: Is it not a fact that these plans do not take into consideration preventive work, and also are they not more or less abused by the people in the high income groups? While I am on my feet I would like to ask you another question with reference to the hospital bed accommodation in the event of insurance coming into effect. Will there be sufficient beds throughout the country to meet the needs; and, if not, what percentage of increase do you think would be necessary?

Dr. STEPHENS: First, on the hospital service plans: it does not matter what your income group is, there are no medical benefits; the individual has the right to pay extra and have a private ward if he wants to.

Mr. McCANN: That is not what I mean. It is generally understood that the hospital plans were put into effect to meet the needs of people in certain income groups.

Dr. STEPHENS: Yes.

Mr. McCANN: And the people who have an income of \$10,000 a year generally pay on a hospital plan with a view to getting cheap medical services. That is one of the objections of the medical profession to the hospital plan: the people who can afford to pay a reasonable fee for their services go in there on a \$2 a month scheme, a good many of them being in a position to pay a decent fee for the services rendered; and in that way they are taking it more or less away from people who are much less able to pay.

Dr. STEPHENS: That would apply to the new medical service plans, I take it.

Mr. McCANN: Yes.

Dr. STEPHENS: The hospital service plan is entirely hospital, and the hospital gets paid. They are charged as private patients, regardless. That is a sound arrangement. Where you have a medical services plan—I cannot answer that. There are many of these medical service plans which include the hospital plan as well. You take the seventy plans about which Dr. Agnew spoke, there are only about ten of them which have medical service plans associated with them.

As to the other point you brought up, I think there will be a tremendous increase. If you are comparing the present conditions with post war conditions, there is going to be a tremendous increase in hospital beds anyway for the after-the-war need; that is understandable.

Mr. McCANN: Where do you expect the wherewithal for that will come from?

Dr. STEPHENS: If the demand is there the hospitals will be built.

Mr. McCANN: By whom?

Dr. STEPHENS: By voluntary organizations, if not by the municipal ones. Wherever there are paying patients you can always get a hospital.

Mr. McCANN: That does not answer the question. Now, I can visualize, in the event of this scheme going into effect throughout the country, that you are going to have an enormous increase in hospitalization facilities, and that will mean an enormous increase in capital expenditure. To whom do hospital authorities look for that expenditure? If they are going to look to the federal authority then that must be taken into very careful consideration in the expense of the scheme that will ensue. If the provinces are going to meet it, then it becomes an entirely different consideration. My own view of the matter is that there is less likelihood of there being much philanthropy, as much as there has been—and there has not been a great deal—in a country like Canada; that we are getting into times when there is less and less philanthropy on the part of well-to-do people because of the increased and ever-increasing taxes that we have in the country. When succession duties were started in the province of Ontario the argument was that succession duties were going to be earmarked for the building of hospitals and for medical care of people. You can see how it has drifted from that. It is going to drift away from that in the other provinces and federally; and none of these funds are going to be earmarked for any special work to be carried on. So, as I say, I can see an enormous expenditure for hospitalization, for those who are interested in hospitalization, and if they expect that that contribution is going to be made by the federal government then we ought to have their views with reference to it. If it is going to be met by the provincial organizations then we can budget more accurately with reference to what the cost of the scheme will be to the federal treasury.

The CHAIRMAN: Dr. Agnew, would you give us some views on that?

Dr. AGNEW: The point raised by Dr. McCann has been discussed by our hospital people from coast to coast because they are all getting behind all the building programmes; but the lack of materials and the preoccupation of our hospital workers in war efforts just means that we are unable at the present time to keep up with the situation. Now, there will certainly have to be a considerable increase after the war; not only the normal increase because of the increase in population and the fact that the people are becoming hospital-minded, but also because of health insurance, and because under that there will be a demand for more beds. Our hospital people, as I would gather their general feelings, take the viewpoint that voluntary effort will do all it can to meet the need; and voluntary effort will go a long way if it is encouraged. But it is very, very questionable if voluntary effort alone can keep pace with these increasing demands; therefore it would seem obvious

that in many areas there will need to be considerable state assistance in a state programme—and I am using that term state assistance in a broad application—whether that will be from the municipality or from the province or from the federal government, it might not be our place to say. All we do is to call your attention to the fact that that need will probably arise.

The CHAIRMAN: Thank you, Dr. Agnew.

Mr. VENIOT: Mr. Chairman, at the top of page 21 of the brief, paragraph 18, reads as follows:

Voluntary hospital and medical care plans should be encouraged for those above the income level (if any).

Now, what I should like to ask Dr. Agnew is this: it has been suggested in certain quarters that voluntary hospitals, as they are to-day, to accommodate people who come under the health insurance scheme would be taken over by the state. Would Dr. Agnew care to express views of the hospital association on that point? I say that as to voluntary hospitals, which will be serving the people who come under the health insurance plan, it has been suggested in certain quarters that they be taken over by the provinces.

Dr. AGNEW: The story in so many European countries on that point has been that the state has gradually taken over voluntary hospitals. That has been the story in Germany and Denmark and in the other Scandinavian countries, so that outside of Holland and Great Britain we do not have very many voluntary hospitals left in the European countries. That may be a development which may come in this country, but the viewpoint of the Canadian Hospitals Council is that such would be very unfortunate. We feel that the voluntary hospital contributes something to our life which must be preserved. The whole voluntary movement should be preserved. Charity should never be entirely lost. It may be that the full cost of caring for a patient, whether they are able to pay their own premiums or not, would meet the actual operational cost but there would still be many other ways in which voluntary hospitals could be of assistance to provide better service to the patients. It would seem to us, Mr. Chairman, that the loss of the voluntary hospitals, their gradual withdrawal from the picture, would be a tremendous loss to the whole country.

Mr. MCGREGOR: Mr. Chairman, indigent patients at the present time do not pay their full share of hospitalization. I suppose that there would be more patients under this new scheme, whether they would be called indigent patients or what they would be called. How would you propose to take care of that? How would that be taken care of?

Dr. AGNEW: Mr. Chairman, it is our interpretation of the draft we have seen that everybody below a certain income level, if that be set, would come under the plan, and that as far as those who are running the services are concerned there would be no difference between the patient who paid his premium and the patient who did not. That is, that the person who could not pay would have the premiums paid into the fund by the state. In that case then every patient coming in, on whatever would be recognized as the standard service in the hospital, would have paid for that patient the same amount from the fund. Whether they had paid into the fund themselves or not would be of no primary concern to the hospital.

Mr. MCGREGOR: The point that I want to make is would they be paying enough from the fund to pay the hospital the actual cost of the patient?

Dr. AGNEW: One point in our brief, Mr. Chairman, is that the hospital should be paid sufficient to meet all operational costs of caring for the patient. I can refer you to that, on page 15.

Mr. DONNELLY: What do you estimate would be the cost per day for hospitalization?

Dr. STEPHENS: It varies very widely. I think the last Canadian figure that we have is \$3.45.

Mr. DONNELLY: Pardon?

Dr. STEPHENS: \$3.45 is the last Canadian figure we have.

Mr. DONNELLY: That takes in the whole dominion?

Dr. STEPHENS: That is a cross section. When Quebec made their readjustment for charity patients they put it at \$4.50 a day. Some of them on the prairies go as low as \$2.00.

Mrs. CASSELMAN: That is exclusive of the medical fee?

Dr. STEPHENS: That is just the hospital work.

Mr. WRIGHT: Does that include retirement of capital expenditure?

Dr. STEPHENS: No, these are all less than cost.

Mr. MCGREGOR: What is the cost in Ontario?

Dr. AGNEW: I will get that.

Mr. McCANN: Dr. Agnew has been referring to what the draft bill stated with reference to those who will come under the scheme, those in a certain income group. This point should be kept clearly in mind that that is not the recommendation of the draft bill. The draft bill is everybody from the cradle to the grave and the Canadian Medical Association and the Canadian Hospitals Council are making a different recommendation. What is the reason that your association puts a limit as to income upon those who shall come under the scheme?

Dr. AGNEW: Mr. Chairman, in the first place we are not making any recommendation as to whether there should be an upper income level or not. We have simply stated in the brief if there be an upper income level, and in the title to one section you will note we have added in brackets "If any", so that we are just leaving our minds open on that point. I will say it is our understanding of the draft measure that whether or not there be an upper income level is a matter which is being left to the provinces. I believe that Mr. Mackenzie has recommended that there be no upper income level but I believe the actual clause leaves it open.

Mr. SHAW: Mr. Chairman, on page 11, section 4, you refer to the controversy over residency and indigency which has been a very real thing in the past. In fact, I think it has been one of the greatest curses with which we have been confronted. Without casting any reflection upon hospitals in particular, or doctors, we have witnessed in connection with many of these municipal hospitals certain deplorable conditions where patients have actually been refused admission even when the doctor recommended admittance. We have definite cases in mind. I would lay particular stress upon the necessity under health insurance of clarifying to the nth degree our definition of indigent so that this controversy will not be carried forward into any new scheme that is proposed. I am afraid it is going to be from what I have heard thus far in this committee.

Mrs. CASSELMAN: Mr. Chairman, when Dr. Stephens spoke just now of the average cost of hospitalization he did not include special nurses? It was just the service as provided by the hospital without any special nurses' fee?

Dr. STEPHENS: Ward service.

Mr. MCGREGOR: Would the doctor put on the record the cost of hospitalization in the different provinces? I think he mentioned Quebec a moment ago.

Dr. STEPHENS: We can very easily get it but I haven't it here.

Dr. AGNEW: Mr. Brady may have them here.

Mr. BRADY: Replying to that question, sir, in a few days a voluminous report on health insurance will be available to the committee, and anything that we do now will be practically only a repetition. We have some copies here, but

the full information regarding every aspect of the questions raised to-day will be thoroughly answered when that report reaches the hands of the committee.

Mr. MCGREGOR: Have you got the cost there?

Mr. BRADY: I will give you briefly the hospital costs by provinces for 1941. For Prince Edward Island the total expenditure for hospitalization was \$154,602, and the average cost per patient day, \$2.35. Nova Scotia, \$1,760,723; average daily cost, \$3.28. New Brunswick, \$1,135,432; cost per patient day, \$3.34. Quebec, \$13,414,168; cost per patient day, \$3.75. Ontario, \$12,883,990; cost per patient day, \$3.25. Manitoba, \$3,048,964; cost per patient day, \$3.37. Saskatchewan, \$2,853,535; cost per patient day, \$3.29. Alberta, \$3,566,510; cost per patient day, \$3.39. British Columbia, \$5,345,999; cost per patient day, \$4. There are a few additions to be made. This refers to general public hospitals.

Mr. McCANN: They are all on the same basis?

Mr. BRADY: They are all on the same basis.

Mr. McCANN: Do they include depreciation?

Mr. BRADY: I may mention to you here that there will be given to the committee the fullest possible information regarding the methods adopted by the Canadian Hospital Association and the Dominion Bureau of Statistics to arrive at an equitable and uniform system of information throughout the nine provinces of Canada. This was commenced a few years ago and has been established, and every province in Canada with the exception of Alberta is supplying the complete information on a uniform system where every item of expenditure and revenue is identical, from province to province. Alberta will be finishing theirs and giving us the report for 1941 shortly. We will give to the committee when this volume reaches your hands any additional reports regarding the complete story of the hospitals in Canada. I may mention to the committee that there is not a public hospital in Canada, not one, in the most remote district, that we have not a complete story for; so that you can take any hospital in Canada and find we place it locally exactly in the census division, and we have related it identically to the population of Canada. Therefore you can take a hospital and you can tell first its name, its type, and then go and find the number of people, where it is located, in what census division, in what county, the number of people from that area who went into the hospital, the number of people living to the square mile in this particular defined area, the percentage of the people hospitalized, the cost per patient day, the revenue, the expenditure, the percentage of the bed occupancy in that particular hospital, the services that that hospital gives, whether they are organized or unorganized. So that this committee or a committee on national health can take any particular division of any province and go there, and if they wish to create a health unit they have the hospital with a complete story regarding what services are available in the various divisions. This will be in the hands of the committee within a few days. But if there is anything now that you would like to ask that is pertinent to the discussion here and if I have it here I shall be only too pleased to support Dr. Agnew's statement.

The CHAIRMAN: This will be all discussed later when the information is available. Any further comments, Dr. Heagerty?

Dr. HEAGERTY: No.

Mr. MACINNIS: May I ask a question on the point raised by Mr. Shaw about indigent patients; I think it is important? My understanding of the purpose of the Act is that indigency will not be a factor; that if it is a contributory basis then the person who is unable to make any sort of a contribution will receive his medical attention and hospital care or medical services without any mention of indigency at all, and that it is likely that persons

in the low income groups under this scheme will pay more under the health insurance plan than they are paying now because they will be paying over a period of time and not in a lump sum at a time when they are less able to pay. I think that is the understanding of the Act I have had.

The CHAIRMAN: Dr. Stephens, will you please introduce the other representatives of the hospital council?

Dr. STEPHENS: I think, Mr. Chairman, the committee might like to hear from Rev. Father Brennan, London, who is the representative on the committee of the English-speaking Catholic group, and subsequently Mother Allaire, who is a member of council not on the committee, but is a representative of the Canadian Catholic Hospital Council.

The CHAIRMAN: Rev. Father Brennan, will you come up here?

Rev. Father BRENNAN: I wish to add my word of congratulation to the members of the council who have been responsible for the preparation of this report and to Dr. Agnew for his presentation. One or two points come to my mind from the discussion already held, particularly with regard to the retention of the system under which voluntary, non-profit hospitals will carry on their work under a national health insurance scheme. It is one of those wide questions—the maintenance of a system of voluntary, non-profit hospitals or their incorporation into a system of state hospitals. I think it is one of the points of discussion where a division of opinion hinges upon regimentation of every department of our life under the auspices of government and the state or the preservation of that measure of freedom which is exemplified by the practice of private charity. I think the nation is enriched in which initiative and individual effort, expressing itself through the medium of charity, finds cooperation and a basis and a method of assistance from society organized and functioning through the state.

On the question of indigency, I think the problem presented by one or two of the speakers disappears very largely in the explanation given more recently by a speaker. So far as the hospitalization of a person who is a beneficiary under the plan is concerned, most of these problems disappear because every one or no one is an indigent. One fraction of the problem remains, perhaps, if the plan were administered on a provincial basis, and that is in the case of a person who is registered in one province and appears for hospitalization in another province. We may have a problem there to work out. But it is only a very minor fraction of the problem which has been rightly described as one of the very unpleasant and unfortunate features of the care of indigents. Thank you, Mr. Chairman, for this opportunity of speaking.

The CHAIRMAN: Thank you, Father Brennan. I would now call upon Rev. Mother Allaire.

Rev. Mother ALLAIRE: I do not think I have come here prepared with anything in particular for this committee. The time given to us after this report was sent to us was so short that we did not have time to have a meeting of our national committee for the study of health insurance. However, we were able to get a few members together and we discussed this report. We find it very good. In fact, I do not see any point on which I could bring up any discussion here to-day. I think Dr. Agnew, with his committee, has prepared a very good report.

If I may, I might emphasize one point which has already been brought out, namely, the necessity of keeping our voluntary hospitals in operation. We have been doing hospital work for very many years—since the very foundation of this country—and have always done it as a non-profit work. We should very much like to be able to continue our work as much as possible in the same way as we have been doing it in the past.

The CHAIRMAN: Thank you very much, Mother Allaire. Are there any further questions?

Mr. SHAW: Mr. Chairman, I should just like to make one point clear, so that a wrong impression will not be left. I referred to residency and more particularly to indigency. I foresaw, of course, a case where no such creature would exist. I would add that if such a thing were to exist, I would oppose the plan; because, after all, if it is not all-embracing, it would not be worth consideration.

The CHAIRMAN: Are there any further questions?

On your behalf, I would like to express our thanks to the representatives of the Canadian Tuberculosis Association, Dr. Wherrett; and also the representatives of the Canadian Hospital Council for their very excellent presentations. I may say, gentlemen, that these gentlemen will be available to cooperate with us and will attend any time they may be required and they will be glad to answer questions at any time they are called. We are very, very grateful to the council.

The committee adjourned at 1.05 o'clock p.m. this day to meet again on Tuesday, April 13, 1943, at 11.00 o'clock a.m.

APPENDIX A

MEMORANDUM OF TUBERCULOSIS CONTROL IN CANADA

PREPARED BY

CANADIAN TUBERCULOSIS ASSOCIATION

April, 1943

Presented by Dr. G. J. Wherrett

This memorandum is prepared for the information of the Committee on Health Insurance in order that they may have readily available some of the salient facts on the tuberculosis problem in Canada and its relation to the proposed health insurance plan. The object of the memorandum is to set out the problem of what has been accomplished in the control of the disease and what benefits are likely to accrue from the adoption of a nation-wide plan for curative and preventive care.

The Problem

For 1900 there were no national figures available on tuberculosis. Such statistics were either absent or incomplete for many of the provinces. We had, however, statistics for Ontario and Quebec, and since these provinces contained the greater part of the population at the time, we can take the rates of those provinces as a fair estimation of the death rate at that time. It was over 200 per 100,000 in Quebec and under 200 per 100,000 in Ontario, and the average was slightly over 200. In 1940, it was 50.6 per 100,000, or a reduction of 75 per cent. It rose to 53.6 in 1941. In 1900 it was the first cause of death. In 1940, it had fallen to eighth place, but in 1941 it was up to seventh place. Throughout all these years it was *the greatest cause of death in young adults from 15 to 45*.

The deaths and death rates for 1941 are as follows for Canada and for the nine provinces:—

DEATHS AND DEATH RATES FROM TUBERCULOSIS FOR
CANADA AND PROVINCES—1941

	Number of Deaths	Rate per 100,000
CANADA	6,051	53.1
Prince Edward Island.....	70	74.5
Nova Scotia	423	73.8
New Brunswick	314	69.3
Quebec	2,681	80.8
Ontario	1,097	29.2
Manitoba	328	45.4
Saskatchewan	286	32.2
Alberta	328	41.6
British Columbia	524	64.8

Nor does this tell the whole story. While there were 6,051 deaths from tuberculosis there were also 30,000 ill and an additional 30,000 who have recovered. The problem facing us is how to prevent these deaths and how to reduce and finally eliminate this cause of illness and disability which takes such a heavy toll of the years which normally should be the most productive of a citizen's life.

The Reduction That Has Taken Place from 1921 to 1941

The first official figures for all Canada are those of the Dominion Bureau of Statistics, which was established in 1921. The figures for 1921 and 1941 are as follows:—

TUBERCULOSIS IN CANADA BY PROVINCES, 1921 AND 1941

(Rates per 100,000 Population)

	1921	1941	Per cent Reduction
CANADA	87·6	53·1	39·4
Prince Edward Island.....	144·0	74·5	48·3
Nova Scotia	134·0	73·8	44·9
New Brunswick	106·0	69·3	35·0
Quebec	122·0	80·8	33·8
Ontario	71·0	29·2	58·9
Manitoba	69·0	45·4	34·2
Saskatchewan	43·0	32·2	25·1
Alberta	53·0	41·6	21·5
British Columbia	78·0	64·8	16·9

The reduction is, however, greater than here set out, owing to the discrepancies in the recording of Indian deaths from 1920 to 1930. In 1921 practically no Indian deaths were recorded. They were included in most of the provinces in 1926 and were not complete until 1928. This increased the death rates particularly in the western provinces which have a higher proportion of the Indian population of Canada.

Prior to 1930 the Bureau of Statistics did not classify deaths as Indian and consequently it is impossible to quote a purely white rate for the '20's.

I think a fair calculation to indicate the reduction in each of the provinces is to take the rates as given for 1921, since they include practically no Indian deaths, and to compare it with the rates in other than Indians in 1941. This gives the following table with an average percentage reduction of 46 for Canada and varying from 63 per cent in Ontario to 34 per cent in Quebec. *It is to be noted that death rates in Quebec and the Maritimes are even now greater than they were in Ontario and Saskatchewan twenty years ago, a fact that clearly indicates the lack of facilities in Quebec and the Maritimes.*

TUBERCULOSIS IN CANADA BY PROVINCES

(Rate per 100,000 Population)

	1921	1941*	Per cent Reduction
CANADA	87	47	46
Prince Edward Island.....	144	74	48
Nova Scotia	134	72	46
New Brunswick	106	67	37
Quebec	122	80	34
Ontario	71	26	63
Manitoba	69	30	58
Saskatchewan	43	21	51
Alberta	53	24	54
British Columbia	78	46	40

* Indians excluded.

The Increase in Tuberculosis in Wartime

Mention has already been made of an increase in tuberculosis since the war. Is the increase a serious one and is it likely to be accentuated? In this matter we can only express an opinion based on the experience of all countries in the last war and on what has taken place in this one.

In the First Great War, tuberculosis increased in all the countries of Europe and also to a slighter extent in Canada and the United States. In countries that

were over-run or deeply involved, the rate increased sharply. In some countries such as Belgium, Austria and Italy, it practically doubled. In Germany and France there was a marked increase. There was an increase in Great Britain from 135 in 1914 to 192 in 1918. In the United States there was an increase from 147 to 150. In Ontario it increased from 88.5 in 1914 to 93.7 in 1916. The rate fell slightly in 1917 and 1918 and immediately declined after the war.

What has happened in the present war? In England, deaths in 1938 were 26,176 and rose to 28,144 in 1940 and to 28,669 in 1941. This was greater than the rise which occurred in the first two years of the last war and was particularly noticeable in children. There was noticed a great increase in tuberculous meningitis. This is thought to be due to a sudden increased infection in the homes, air raid shelters and industries. When the war came the British expected thousands of air raid casualties and hospital beds were made available to handle them. Some 12,000 tuberculous patients were sent home from sanatoria. Many of these were infectious cases and it is not hard to understand the sudden increase in the disease in the children of the country. When to this was added evacuation and life in the shelters, and the additional stresses, physical and psychological, imposed by war conditions, many tuberculous patients went rapidly down hill and died in 1940 and 1941, and increased infection was beginning to take its toll in the age groups from 5 to 15.

In Canada we have not had the evacuation of sanatoria or the bombing, but our whole tempo of life has been speeded up. In 1939 the rate was 50. It remained at 50 in 1940 and increased from 50 to 53 per 100,000 in 1941. We have not complete figures for 1942. There has been some reduction in the first six months as compared to 1941. This leads us to believe that if preventive services are kept up the disease will be kept in check, but some ground will be lost.

TUBERCULOSIS IN THE FIRST WORLD WAR

Country	1914	1918
Austria	256	432
Belgium	124	245
Germany	143	230
France	228	246
Italy	145	209
England and Wales.....	135	192
United States	147	150

(Rates are per 100,000. From Report of Health Section, League of Nations)

Important factors in the control of tuberculosis are *early diagnosis* and *prompt treatment*.

Early Diagnosis

For many years sanatorium directors were discouraged by the high percentage of far advanced cases who came for treatment as compared to those whose disease was early. The results are in marked contrast. About 80 per cent of the early cases recover, but in the case of the far advanced, the percentage who recover is reversed.

Why are so many patients far advanced when diagnosed? The reason is that the disease is often advanced before there are symptoms and before the patient consults the family doctor. It was to meet this challenge that the tuberculosis clinic was started over twenty years ago. It was to provide X-ray facilities and expert advice that would be available for all physicians to refer patients on the slightest suspicion of tuberculosis. It has become one of the most important factors in the campaign. Its functions have widened since it first came into existence. Now it serves as a centre for the *examination of all suspects referred by doctors*, but it also *supervises all patients discharged from sanatoria*. It *examines all contacts to known cases*, who may have been exposed

to infection. The latest venture is the *X-raying of groups of apparently well people*. Many groups are examined each year. The chief ones are: School children, normal school students, university students, teachers, nurses, industrial groups, mass surveys of whole municipalities, towns and cities.

The X-ray examination of recruits for the armed forces was the upshot of such experiences. Results have more than justified the procedure. Eight thousand have been rejected because of tuberculosis and about one-third of these needed treatment. It is probably no exaggeration to say that if this had not been undertaken, many of them would have infected others. This procedure alone will save the country millions in treatment and pension. One has only to compare the large numbers under treatment in the last war with the few under treatment so far in this one to understand the marked difference.

There is still much to be done to improve clinic facilities in Canada. These require adequate medical staff and public health nurses. X-ray equipment is necessary and facilities for applying modern methods of treatment such as lung collapse for patients for whom sanatorium treatment is no longer required. Whenever possible, travelling clinics at unstated intervals should be replaced by regular clinics at regular intervals.

Mass surveys should be developed using the newer type of miniature X-ray apparatus now in use. This holds great possibilities for the early diagnosis of the disease. Early diagnosis means shorter periods of treatment, more recoveries and a more efficient use of sanatorium facilities. While an early case may require only six months of sanatorium treatment, a far advanced case may require eighteen months or longer, and the patient may die. In other words, you can treat three early cases for every one that is far advanced, and with greater success in saving each patient's life.

Treatment

The other factor that has been mentioned is that of prompt treatment. This depends on whether a sanatorium bed is available and whether treatment is free. For every person who dies there are two to three who require a bed in a sanatorium, or in other words, for every death you require two to three sanatorium beds. The provinces that have reached this quota are Ontario, Manitoba and Saskatchewan. Many more beds are needed to give the other provinces the same ratio.

It is a great advantage for the treatment of tuberculosis to be free to all. Over 90 per cent are treated without charge anyway and it removes a great barrier to early treatment if it is free.

A study was made of the delay in the admission of newly found cases to sanatoria in each of the provinces. The percentage who were admitted within a month gives us a good index of prompt treatment. The figures for the year 1940 are as follows:—

P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
21·3	25·4	22·8	36·6	60	67	83·2	67	47·5

In the year for which these figures are quoted, in the provinces of Ontario, Manitoba, Saskatchewan and Alberta, treatment was free to all in two of the provinces, and in the others it was practically so. In all, the costs were distributed evenly over the provinces and did not fall unduly on any individual or municipality.

There is urgent need in Quebec, Nova Scotia and New Brunswick for relieving individual municipalities of the burden of tuberculosis costs and for a system whereby the costs would be evenly distributed over the entire province.

PROPORTION OF TREATMENT BEDS IN CANADA TO DEATHS

	Deaths	Beds	Ratio of Beds per Death
CANADA	6,051	11,301	1.9
Prince Edward Island.....	70	82	1.2
Nova Scotia	423	597	1.4
New Brunswick	314	540	1.7
Quebec	2,681	3,503	1.3
Ontario	1,097	3,638	3.3
Manitoba	328	920	2.8
Saskatchewan	286	762	2.7
Alberta	328	409	1.2
British Columbia	524	850	1.6

The number of beds has a more direct relation to the population in each province than to the extent of the tuberculosis problem. That is to say there is approximately one bed per 1,000 of the population. In provinces which have a low tuberculosis rate this quota of beds is sufficient, but if there is three times the number of tuberculosis patients, it means that one bed per 1,000 may be only one-third of what is required.

The Need for Federal Grants-in-Aid

The proposed health insurance plan outlines Federal assistance required for the development of public health services and grants-in-aid for specific problems such as tuberculosis, mental disease and venereal disease. We endorse this principle wholeheartedly. As far as the problem of tuberculosis is concerned, we believe that there are no administrative difficulties or obstacles to be overcome in implementing this part of the proposed plan. The plans at present in operation in the provinces are functioning well, but we realize that they are inadequate, particularly in certain parts of the country. Federal subsidies as provided in the plan would assist the provinces to augment, improve and standardize procedures so as to deal adequately with the problem in all parts of Canada. At present, the programme does not make this possible. In principle, the plan is implementing recommendations made over and over again by the Canadian Tuberculosis Association since its inception in 1900. It is implementing specific recommendations made by the Association to the Royal Commission on Dominion-Provincial Relations in January, 1938.

We believe grants-in-aid should be given on certain conditions and that the provinces should be asked to conform to minimum standards before being allowed to participate in such grants. We have drawn up a memorandum on such minimum standards, after consultation with the provinces, and have submitted it to the Hon. Mr. Mackenzie's committee.

We are, of course, deeply concerned with the size of the proposed grant. It is true that similar grants will be given for mental diseases as well as grants for venereal disease and general public health administration, and in all, the provinces would receive a considerable sum to augment their present public health budgets.

As regards tuberculosis, the province of Quebec and the Maritimes have a tuberculosis problem three times that of the other provinces. They would require to gradually increase their tuberculosis expenditures to conform to what is considered minimum standards. For this they would only receive one-ninth. We would recommend that provinces having a tuberculosis problem much in excess of the Canadian average might receive in addition special grants-in-aid to assist in sanatorium construction that is urgently required.

We would like to stress the present losses from tuberculosis. We still have 6,000 deaths annually, 30,000 disabled, mainly in the age-group 15 to 45. There are also great hidden losses from relief widows' pensions and mothers' allowances, not to mention loss of earning power.

Tuberculosis has been cut in half in twenty years even with inadequate facilities for diagnosis and treatment. Tuberculosis can be reduced to a minor cause of death in one generation under a nation-wide coordinated plan providing adequate facilities. Not only is it sound financial policy over a period of years, but the tremendous benefits in health and happiness to the people of Canada dwarfs the expenditure required for this purpose.

PLAN FOR TUBERCULOSIS CONTROL

Provinces that are undertaking a comprehensive programme for tuberculosis prevention and control will be eligible to participate in federal grants, under a Federal Health Insurance Act.

Such federal aid would be contingent on the following minimum requirements immediately available or provided within a reasonable time.

Such provinces will provide either a central registry or district registers, so that information will be available on all known cases of tuberculosis in the provinces, with a record of the supervision of such cases until such time as supervision is no longer required. Such provinces would provide the following facilities:—

(1) *Case-Finding*

Clinics shall be made available, to which patients may be referred by all registered physicians. These shall be held at regular intervals in centres of population. Travelling clinics shall be available in more remote areas. Such clinics shall be conducted by fully qualified physicians, specially trained in the diagnosis of chest diseases. Such clinics shall be provided with adequate X-ray and laboratory facilities.

Such clinics shall undertake the supervision of all contacts to known cases, and in co-operation with the family physician shall undertake the regular follow-up and supervision of patients under treatment at home, or discharged from the sanatorium.

Such clinics shall undertake to foster and encourage the use of surveys in population groups, and periodic examinations including the use of X-ray, or the tuberculin test and X-ray. Such surveys would apply particularly to those engaged in hazardous industries, or population groups showing a higher incidence of tuberculosis than the average population.

(2) *Treatment Facilities*

(a) Sanatorium facilities must be provided for the isolation and treatment of all open cases. There shall be provided two, and preferably three, beds per annual death, and such federal grants may be used for sanatorium construction to bring this quota up to this ratio.

(b) The cost of treatment shall not be a barrier to prompt admission to a sanatorium. Free treatment for all bona fide provincial residents is advised.

(c) Sanatoria must be adequately staffed. Competent medical, nursing and dietetic services must be made available and the treatment of patients shall be supervised by a full-time physician possessing special training in the treatment of tuberculosis. Facilities for collapse therapy and chest surgery shall be available, either in each institution, or in one or more provincial institutions that will be available to those institutions not able to support a service in chest surgery.

(3) *After-Care and Rehabilitation*

A plan of after-care and rehabilitation must be in operation comprising at least the supervision of the patient after discharge and the use of after-care committees or supervision by local boards of health to advise and assist in adequate relief work and placement.

(4) *Education*

A programme of education must be in operation that shall include adequate facilities for training physicians and nurses in the work of tuberculosis control.

A programme of health education for the general public must be undertaken, using modern methods of health instruction and working through population groups such as schools and colleges, normal schools and universities, men's and women's organizations, and service clubs, and using methods available, such as the radio, press, public meetings, moving pictures, posters, and printed matter. This programme should be carried out by official or voluntary agencies. In carrying out such teaching, stress is to be laid on the use of voluntary agencies and lay committees as an essential part of our democratic way of life.

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SESSION 1943
HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 7

TUESDAY, APRIL 13, 1943

WITNESSES:

Miss Marion Lindeburgh, President, Canadian Nurses Association;
Miss Baker, representative private duty and general nursing;
Miss Ellis, emergency nursing adviser;
Miss Edna Moore, public health nursing administered by agencies;
Miss Maria Roy, representing French-Canadian nurses;
Miss Alice Ahearn, chairman of subcommittee on health insurance;
Rev. Sister Madeleine, representing Catholic Sisters;
Miss Maude Hall, public health nursing by voluntary agencies;
Miss Fannie Munroe, representing nursing service in hospitals;
Dr. T. C. Routley, General Secretary, Canadian Medical Council;
Rev. Mother Allaire, Chairman, Catholic Hospital Council, Health Insurance Committee.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

TUESDAY, April 13, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Bourget, Breithaupt, Bruce, Casselman (*Mrs.*), Claxton, Cleaver, Côté, Donnelly, Fauteux, Fulford, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIlraith, Picard, Shaw, Veniot, Warren, Wood, and Wright—33.

Miss Marion Lindeburgh, President of the Canadian Nurses Association, was called. She introduced the following members of the delegation of nurses:—

Miss Baker, representing the private duty and general nursing field;

Miss Ellis, emergency nursing adviser;

Miss Edna Moore, representing public health nursing administered by official agencies;

Miss Maria Roy, representing French-Canadian nurses;

Miss Alice Ahearn, chairman of subcommittee on health insurance and nursing service;

Rev. Sister Madeleine, representing Catholic Sisters in the Canadian Nurses Association;

Miss Maude Hall, representing public health nursing by voluntary agencies; and

Miss Fannie Munroe, representing nursing service in hospitals and schools of nursing.

Miss Lindeburgh then presented a brief for the Canadian Nurses Association and was questioned by the committee.

The following witnesses were also examined:—

Miss Ellis, Miss Baker, Miss Munroe, Miss Hall and Miss Moore.

Dr. T. C. Routley, General Secretary, Canadian Medical Association, was recalled and further examined.

Miss Maria Roy, Director of Nurses, City Department of Health, Montreal, presented a brief in French, which translated, is included in this evidence.

Rev. Mother Allaire, Chairman, Catholic Hospital Council, Health Insurance Committee, was called and addressed the committee.

Rev. Sister Madeleine was called, and addressed the committee.

Mr. Bruce and Mr. Picard expressed their approval of the presentation given by the witnesses, and Miss Lindeburgh, on behalf of the Canadian Nurses Association, expressed appreciation of the hearing given them by the committee.

The chairman thanked the witnesses for the evidence they submitted.

The witnesses retired.

The committee adjourned at 12.45 p.m. to meet again at the call of the chair.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

APRIL 13, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Order, please; we have the privilege this morning of hearing from the Canadian Nurses Association and other allied organizations. The first representative is Miss Marion Lindeburgh, president of the Canadian Nurses Association. Will you please come forward, Miss Lindeburgh?

Mis^s MARION LINDEBURGH, called.

By the Chairman:

Q. Miss Lindeburgh, you are also director of the School for Graduate Nurses at McGill University; is that correct?—A. Yes.

Q. Would you proceed in your own way with your statement, please?—A. Mr. Chairman, Mr. Minister, Mrs. Casselman and gentlemen: It is my privilege to express appreciation on behalf of the Canadian Nurses Association for the invitation to appear before the Special Committee on Social Security to present pertinent facts regarding nursing which is an essential health service.

Mr. Chairman, I would like to introduce the members of our association. I will just take them by rows. Would you stand as I mention your names.

Mr. BRUCE: Just turn this way, too.

The WITNESS: And turn, because I imagine questions that way may be more personal. This is Miss Baker, representing the interests of the private duty and general nursing field; Miss Ellis, known to the Canadian Nurses Association as Emergency Nursing Adviser, an imposing title and position. She is acquainted with nursing problems across Canada. Miss Edna Moore, representing public health nursing field administered by official agencies; Miss Roy, representing the interests of our French nurses in the Canadian Nurses Association; Miss Alice Ahearn, chairman of our subcommittee on health insurance and nursing service; Rev. Sister Madeleine, representing the interests of our Catholic Sisters in the membership of the Canadian Nurses Association; Miss Maude Hall, representing the interests of public health nursing administered by voluntary agencies; Miss Fannie Munroe, representing the interests of nursing service in hospitals and schools of nursing.

By word of explanation I should like to say that because of the very short notice that was given to us we have only had a few days in which to prepare this brief, and because of this fact there are corrections which should be made in the copies which you have in hand. Some of the copies have been corrected and some have not. I might say this material just came off the press about 8 o'clock last night, and for that reason there has been no time to refine it. However, your copy is corrected, Mr. Chairman, and also the Minister's. May I proceed, Mr. Chairman?

The CHAIRMAN: Yes, please.

The WITNESS:

"CANADIAN NURSES ASSOCIATION"

1. *Organization; Membership; Objectives*

The Canadian Nurses Association is a federation of the nine provincial nurses associations. It was founded in 1908 and its further development is a story of rapid growth. It now has a membership of over 19,000 of whom 760 are English-speaking and 440 French-speaking Catholic Sisters and 1,650 French-speaking nurses.

The membership of the Canadian Nurses Association includes all registered nurses practising in Canada with the exception of approximately 6,900 nurses in Ontario and possibly a very few in Prince Edward Island. In both these provinces the Act governing registration of nurses is distinct from membership in the provincial registered nurses association, although registered nurses in these provinces are eligible to join the provincial associations and many of them do so. In the seven other provinces registration includes membership in the provincial registered nurses association. In all these associations membership is renewed each year.

The national office of the Canadian Nurses Association is at 1411 Crescent Street, Montreal. The official organ of the association is *The Canadian Nurse*.

Membership in the Canadian Nurses Association is drawn from every branch of nursing service; this includes hospital, public health, home visiting and private duty nursing.

Since its inception the objects of the Canadian Nurses Association have been:

- To promote national unity among nurses in Canada;
- To elevate the standard of nursing education and practice in order to render the best type of public service;
- To stimulate in its members an active interest in community welfare;
- To encourage the attitude of understanding towards nurses of other countries."

These are the objectives as stated in the constitution of the Canadian Nurses Association.

"In any modern community, nursing service is rightly regarded as an indispensable public utility. It has an essential place in health insurance. The responsibility of interpreting nursing service and of presenting recommendations for its most effective implementation in any health insurance plan is one that rests with the Canadian Nurses Association, as the national organization representing registered nurses throughout Canada.

2. *Nursing Services Represented Within the Canadian Nurses Association*

The nursing services, sponsored and supported by the Canadian Nurses Association are included in three major fields:

(a) *Nursing in Hospitals.*—Nursing service in hospitals conducting schools of nursing is provided by graduates and students. Nurses' aides and helpers are also employed to undertake non-nursing duties. Until recent years the nursing load was carried almost entirely by student nurses. This practice is unsound from the point of the student and the patient. The student's clinical programme should be carefully planned to meet her educational needs, rather than to meet the demands of hospital nursing service, and patients in many instances are too ill to be nursed by students. Hospital Administrators have become aware of the need for stabilizing nursing services, and improving the quality of nursing given through the employment of graduates as general staff nurses. Over three thousand more graduate nurses are employed in general duty in hospitals throughout Canada to-day than was the case ten years ago.

Besides the general nursing staff, the nursing personnel includes those with post-graduate preparation and experience who are responsible for the administration and supervision of the various nursing services. Nurses with special technical training are employed in X-Ray, Physiotherapy, and other hospital departments.

(b) *Private Duty Nursing*.—Approximately 75 per cent of nurses in Canada are engaged in private duty nursing. The value of the good private duty nurse in conditions of serious illness cannot be questioned. One of the existing weaknesses in private duty nursing service as it exists to-day is in the fact that the patient who can afford to pay the cost for private nursing care receives it, while the patient who urgently needs it may go without because of lack of the necessary financial resources.

The establishment of an eight-hour day for private duty nursing is long overdue. It has placed however an additional financial burden on the patient requiring continuous nursing care, while the actual income of the nurse has not been increased. The yearly average income of the private duty nurse does not provide for more than a subsistence maintenance. When a health insurance plan is established this situation should be alleviated to a great extent.

In every province placement bureaux or registries are established for the purpose of answering all calls for nurses who are accepting employment on a daily basis. These registries experience much difficulty in the adequate distribution of nurses and in securing the most suitable nurse for the particular patient. The prerogative of choice suggested in a submission to this committee for doctor and patient might equally apply to the nurse-patient relationship. It is significant to note that with very few exceptions the financial upkeep of nurses' registries is maintained by the nurses themselves, with no assistance from the community which they serve. Presumably the scope of these placement bureaux will be enlarged under any scheme of health insurance. Therefore it would seem that the necessary financial support should be considered for their maintenance.

(c) *Public Health Nursing*.—This service includes home visiting, school nursing, industrial nursing, preventive and health work in child welfare, maternity, tuberculosis, venereal diseases and other special fields in which public health nursing has become an essential part of a health programme in both rural and urban communities. Health teaching is an important function in all public health nursing work. Public health nursing is administered by official and voluntary agencies. These services as administered by provincial and municipal departments of health have proved their value. Nurses with special preparation are being needed in increasing numbers for staff and supervisory positions in public health departments across the country.

There are several well recognized voluntary nursing services organized to meet community nursing needs in all parts of Canada. The standards of qualifications of staff and systematic supervision provided reflect the calibre of these organizations.

It is particularly important that in the development of a health insurance plan which is to provide adequate medical and nursing care in conditions of illness and to promote the health of individuals and families that the above mentioned nursing services be recognized by physicians, hospital and public health authorities, as well as the general public, in order that available services may be fully utilized.

(d) *Schools of Nursing*.—the source of supply from which all nursing service stems.—Increased nursing demands will inevitably result from any health insurance plan. It is therefore of primary concern that schools be well maintained in the establishment of health insurance. A continuous supply of properly prepared nurses must be assured. Adequate educational and residential facilities are essential.

There are 166 approved schools of nursing in Canada conducted by general hospitals, with a total enrolment of approximately 11,000 students. About 3,000 of these graduate annually. Nine universities conduct either schools or departments of nursing. The standards for approval of schools and eligibility of nurses to register are determined by acts governing the registration of nurses within each province, although reciprocal registration privileges exist between the nine provinces.

In order to ensure an adequate supply of well-qualified graduate nurses to support a health insurance plan, it is necessary that enrolment be maintained in schools of nursing of a sufficient number of desirable students. If this enrolment is to be sustained at a satisfactory level, it is obvious that students in schools of nursing must be offered advantages equal to those recognized as essential in other forms of education and that these must be afforded under conditions that support sound principles of learning.

It is essential that properly qualified teachers and supervisors be responsible for the class room and clinical experience of student nurses. This is of vital importance from the point of view of nursing service in hospitals, because the quality of nursing care which students render to patients is in direct relation to the quality of teaching and supervision which they receive.

It must be borne in mind that clinical facilities are as necessary for nursing education as for medical education. Only through continued practice of nursing patients under adequate supervision can the student become skilled in nursing arts. A definite ratio of graduate nurses to students is essential in a good school of nursing.

Reasonable hours of duty and allowance of time for study and recreation are obviously part of any educational programme. This applies to both students and the nursing staff. Provision should be made for these.

All these factors indicate the necessity for financial assistance from governments to maintain the necessary quality and quantity of nursing essential in any health insurance scheme. The generous aid given through the Department of Pensions and National Health in 1942 to assist schools of nursing to increase student enrolment has quickly evidenced the value of financial support.

3. *Ancillary nursing service*

The care of convalescents and others who do not require highly skilled nursing care is recognized as very important in meeting the needs of the community. In order to safeguard the public, it is essential that all nursing and ancillary services be provided through organizations which are representative of registered nurses. In many provinces ancillary nursing service is already provided through placement bureaux conducted by the registered nurses association."

We come now to a closer consideration of nursing in relation to health insurance.

HEALTH INSURANCE

1. *The Canadian Nurses Association approves the general principles of health insurance*

The Canadian Nurses Association has been interested for some time in the subject of health insurance and in the initiation of a plan by which nursing services could be utilized most effectively in meeting the health needs of the people of Canada.

Since 1934 a special committee of the Canadian Nurses Association has functioned for the purpose of studying schemes of health insurance in the event of the adoption of a plan on a federal or provincial basis.

In 1935, at a conference between federal and provincial ministers of health on the question of health insurance, the Canadian Nurses Association presented a plan of nursing service for consideration. Again in 1938, the Committee on

Health Insurance and Nursing Service of the Canadian Nurses Association prepared a brief which was submitted to the Royal Commission on Dominion-Provincial Relations, in which emphasis was placed upon the importance of making provision for adequate nursing service as an integral part of a health insurance scheme.

The Canadian Nurses Association is interested and anxious to participate in any plan whereby the best which organized nursing can offer will be preserved and utilized to the greatest advantage.

The six principles of health insurance which appear in the report of the Honourable the Minister of Pensions and National Health, and recorded in the minutes of the proceedings of March 16th are worthy statements, the first of which is basic to an effective nursing service "that no scheme of health insurance can be successful without a comprehensive public health program of preventive nature". This statement implies that effective public health education and health supervision must be made possible.

Because of the shortage of nursing staff in hospitals and public health nursing organizations over a period of years, teaching as an essential aspect of nursing has been the weakest feature. Sufficient time and a well qualified staff are necessary for effective health teaching and supervision.

The nursing benefit as included in the draft bill under consideration embraces essential factors relating to organization, administration and control of nurses and nursing which were outlined in greater detail in the brief submitted by C.N.A. at an earlier date. It would appear to cover the fundamental policies upon which provincial nurses associations can build their recommendations pertaining to nursing service, when the provinces implement a health insurance plan.

The recommendation made by the Canadian Hospital Council (item 18 under the caption "Essential Principles") is of vital importance. In part it reads as follows: "Because of the vital importance of the health of our people to the national welfare, it is most desirable that the direction of the plan be kept strictly non-political".

2. Nursing an essential service in a health insurance plan

Health insurance for the people of Canada means in the first instance a greater recognition and appreciation of the benefits of medical care in the therapeutic, preventive and health measures. The expansion of medical services is inherent in the scheme. This fact will necessitate the extension of nursing services in all fields in the development of a plan in which the co-ordination of medicine and nursing is essential to the welfare of the individual whether in the home or the hospital. These services are complementary to each other.

3. Nursing under health insurance

(a) Representation on the commission and advisory boards.

Standards of nursing and problems of nursing service are best understood by the nursing body, therefore in the interests of the people to be served it is recommended:

That, when the health insurance plan is organized, federally and provincially, responsible registered nurses be appointed to all boards and committees whose functions include the direction or supervision of nursing services and that these appointments be approved by organizations representative of registered nurses.

(b) Control of standards of qualifications and nursing service.

The advance in medical sciences and the trend toward specialization in medical practice have affected the objectives and practice of nursing. Nurses must be prepared to function in special fields and in various executive capacities. It is becoming increasingly recognized that certain positions should be filled only by nurses with special preparation and experience.

Departments of nursing in universities offer courses which qualify graduate nurses for teaching, supervisory and administrative positions. To assure effective administration and supervision of nursing in a health insurance plan it is of vital importance that the selection of qualified personnel be in relation to the responsibilities of the positions to be filled.

(c) Distribution and stabilization of nursing services. The importance of a satisfactory nursing service in rural areas needs to be emphasized. More recognition and assistance should be given to nurses working under many handicaps in outlying parts of the country. If conditions of living could be made more attractive, and service more remunerative, the nursing needs of rural communities could be met more adequately.

Small hospitals in rural areas have difficulty in securing and retaining satisfactory nursing personnel. Salaries are usually low, and this coupled with limited social and educational advantages tends towards too frequent change in nursing personnel. The rural population of Canada is deserving of better medical and nursing services than have been supplied heretofore and provision for the necessary facilities for adequate health services is an important consideration in the health service plan.

The greatest handicap in attempting to stabilize nursing services in all fields, in hospital and community, arises from too long hours, inadequate remuneration and insufficient time to allow for satisfactory accomplishment of nursing care. Routine hospital duties are in too many instances assigned to nurses, both graduates and students, which could and should be delegated to ward aides and helpers. It is apparent that the nurse's time should be conserved for the care of the patients, and non-nursing duties assigned to a lesser skilled and lower salaried worker. All these factors predispose to discontent, discouragement and instability of the nursing personnel.

With the increase of hospitalization which inevitably will accompany health insurance, provision should be made for adequate nursing staff and more satisfactory working conditions.

CONCLUSIONS

While the inclusion of the nursing benefit in the draft bill is evidence of the recognition of nursing as an entity in the plan of health insurance, it must function as an integral part in the whole scheme. A mutual understanding of the objectives and activities of all groups involved is necessary for the most effective cooperation in a coordinated health insurance plan.

The Canadian Nurses Association wishes to assure the Special Committee on Social Security that its members very earnestly desire to share in the development of a plan which will safeguard and promote the health of the people of Canada."

Might I add that this submission has been prepared upon very short notice, not allowing sufficient time for it to be reviewed by all members of the executive committee, Canadian Nurses Association, and by the provincial associations of registered nurses. Therefore it is hoped that if the need arises opportunity will be given for further discussion with this committee.

By Mr. McCann:

Q. Mr. Chairman, on page 8 of the brief at the top of the page the following appears:—

The generous aid given through the Department of Pensions and National Health in 1942 to assist schools of nursing to increase student enrolment has quickly evidenced the value of financial support.

I think it would be to the advantage of the committee if the minister would give us some details with reference to what that assistance has been.—A. I

should be very pleased to answer the question. The Canadian Nurses Association appealed to the Department of Pensions and National Health for financial assistance in this war emergency. We are in a serious condition with regard to nursing in Canada because of shortage. Our first duty is to meet the demands of the armed forces for overseas, and, as you possibly know, there has been a great drain upon the nurses in Canada. We wish to keep up that supply; we must do it, but at the same time we must take care of civilian nursing services not only during this war period but we must look to the future; and the Department of Pensions and National Health very generously approved a grant of \$115,000 for nursing needs in Canada in the past year. Of this \$75,000 went to the support of schools of nursing in order that they could enlarge their facilities to bring in more students so that we might in as short a time as possible have more graduates. \$25,000 went to the university schools of nursing in order to promote teachers and supervisors for public health fields and for schools of nursing, to improve the services, and also for the teaching of students in those fields. \$15,000 went to the administration end of this programme under the direction of our emergency nursing adviser, Miss Ellis, who is with us this morning. That has taken care of her salary and publicity and the essential needs. That has done marvellously well for us in this last year and I should like to say before this committee that we are truly grateful to the Department of Pensions and National Health in assisting in the serious emergency.

Q. On what basis was that \$75,000 distributed and did any of it actually reach the individual schools of nurses, as far as increases in salaries were concerned?

Miss ELLIS: Mr. Chairman, I think some of the schools in every province have definitely benefited from the grant in different ways; one way has been by subsidizing or paying the entire salary of additional clinical supervisors because with the increased enrolment of students and the decrease in the ordinary supervisory help in the hospitals, schools of nursing are meeting very serious difficulties in training students and preparing them. In most of the provinces it was felt that the larger schools were better equipped and better able from the standpoint of direction of students to provide them with what they needed by affording them the necessary facilities for teaching. In all provinces a number of schools have received support or assistance by the appointment of one or more clinical supervisors. In addition, the schools in a number of provinces have received assistance in supplementing equipment and reference books for their libraries and teaching facilities. Then, some of the schools have been given the facilities for increasing the teaching of public health to their students. That is directed to the public health field; but it has been through the public health organization that the students in the individual schools have benefited by gaining that experience under properly qualified supervisors. In other provinces, not in all, travelling instructors have been appointed who have gone about from school to school and assisted inexperienced young head nurses to more rapidly take on promotion. It may be that they are not prepared altogether for that, but because of the shortage they had to assume the responsibility. In a number of provinces I think that has proved a very valuable appointment.

Mr. FULFORD: Mr. Chairman, in paragraph 3, page 7, I find the following:—

A definite ratio of graduate nurses to students is essential in a good school of nursing.

I wonder if Miss Lindeburgh would tell the committee what is considered the proper ratio.

The WITNESS: Miss Ellis, I think you have made a study of that and I think you should answer it.

Miss ELLIS: That largely depends on the physical set-up of the situation, the type of patient being cared for, the general arrangement and so forth, but I think it is an accepted statement after a good deal of study in the profession that probably one to three or one to four is a very fair ratio, one graduate nurse to every three or four students. That includes, of course, the supervisors.

By Mrs. Casselman:

Q. To return to the question as regards the grant given, I wonder if the association feels that it has brought in as many students as the association could handle with the present staff. That is, you have a certain grant for inspectors and supervisors; have you been successful in getting the student nurses and have you as many now as you can handle with your present staff?

Miss ELLIS: There has been an increase of approximately about 1,000 students in school nursing in Canada since the outbreak of the war. Mr. Chairman, I think in reply to Mrs. Casselman's exact question the schools have been successful in securing all the candidates they could take care of and I may say the enrolment certainly has been sustained better than it would have been without publicity by recruiting and so forth; but some schools still have more applicants than they can take care of. By and large I think there is probably a scarcity of applicants, certainly there has been a marked decrease in the number of applicants. I think that must be expected when we think of the demands being made upon woman-power to-day and also the fact that some of these young women can go immediately into positions where they are getting high salaries, so that the nursing profession is really meeting stiff competition. I do not think the recruitment in the past year has succeeded in getting them out to the numbers that the schools could take care of, but it certainly has kept it from decreasing as materially as we feared at one time.

Mr. WRIGHT: I take it for granted that none of this money has gone to the individual nurses or students by way of a grant to encourage them to enter the profession. I think it is a considerable drain on the individual student who enters a nursing school, and I imagine if some provision were made whereby they would receive some financial assistance probably there would be more entering the profession. I wonder if Miss Ellis would comment on that.

Miss ELLIS: No, none of the money was used to subsidize student nurses. Am I right, Mr. Chairman, when I say that we were given to understand that this might be undertaken under the youth training plan? Representations have been made to that department whereby it is hoped that subsidies to student nurses will be made available, but up to the present time none of the money has been expended for that purpose.

By Mr. McGarry:

Q. On the top of page 4 I find the following:—

Approximately 75 per cent of nurses in Canada are engaged in private duty nursing.

Would you include private nursing in the hospitals in that?—A. Total nurses in homes and hospitals, private, civilian and hospitals and homes of the people.

Q. Would you be able to say just where the greatest scarcity of nurses would be now, private nurses or hospital nurses?—A. Would there be much discrimination, Miss Ellis?

Miss ELLIS: General duty nurses.

The WITNESS: I know what we speak of as our general nursing group, and then there are nurses who are on the general staff, nursing in the hospitals and who take care of several patients. We speak of the private duty nurse as a nurse taking care of the individual patient.

By Hon. Mr. Bruce:

Q. I should like to ask a question dealing with the same page. You say at the beginning of the second paragraph:—

The establishment of an eight-hour day for private duty nursing is long overdue.

Do you mean that literally? Is it not a fact that that is already existing in certain provinces? How general is the eight-hour day in use?

MISS BAKER: Mr. Chairman, the eight-hour day is in use in some of the provinces, but not in all of them. Then, it may be used in some provinces and some parts of each province, but in some localities it may not be used.

MR. LALONDE: In what provinces?

MISS BAKER: The provinces in which the eight-hour day for the private duty nurses is used in Ontario, in Quebec to a certain extent but to a lesser extent than Ontario, Manitoba, Saskatchewan, Alberta and British Columbia. When you get down to the maritimes it is not used as extensively there.

MR. BRUCE: I would like to add my testimony to the value of the eight-hour day. I quite agree that it is long overdue, and I think the nurses themselves can give better service if they work only eight hours a day. It is a great imposition to ask nurses to work twelve hours a day as was the practice heretofore. The need for nurses is a matter for the individual, and that matter should be overcome in some other way.

HON. MR. MACKENZIE: With regard to this grant, I suppose the results would not be evident or visible after one year's operation; it would be cumulative over a period of two, three or four years?

MISS MOORE: I think any comparison would have to be made over an accumulation of years, but even in the short time it has been in use I think there is evidence of what the value of the grants would be. It will be necessary to support the activities that have been undertaken because of the grant in order that they may mature and bring results.

MR. MACINNIS: I was wondering if Miss Lindeburgh would care to elaborate on the last paragraph on page 7: hours and duties for students. I understand that those hours are excessive and are detrimental to the health of the students and that there are continual breakdowns in health?

MISS LINDEBURGH: We who trained some years ago can think of twelve hours duty with the understanding that we would have two hours off, but when we had the hours off we had to go to class, so between going to class and nursing patients in the wards it was a twelve-hour day. Now we are getting along, conditions are getting much better. Our curriculum for schools of nursing in Canada suggest an eight-hour day for student nurses, and they will have time off, at least a day off during the week. It is suggested that their classes should not be extra to their working day. I think if we examine schools of nursing in Canada to-day we will find that many of them have a ten-hour day and that possibly includes two hours of class. However, in many instances we know that the hours of student nurses are still much too long. People will say that the students are on from seven to seven, with four hours off somewhere and that makes eight hours. You will find that as far as the four hours are concerned much of the time is used up with getting lunch and going to classes and those students are still working far too long. We are looking forward to the time when student nurses will be considered as students are considered in other professional schools and where the work on the wards will be considered in terms of practice. Every professional school must think of its curriculum in terms of theory and practice, and that practice will be in relation to educational

needs, and not in relation to meeting the need of the hospital, over and above what they need for the development of their practice in the making of a good nurse.

MISS MUNROE: In addition I should like to emphasize what our president has said, that we all feel that an eight-hour day and a six-day week will be a very desirable thing for the student. The students themselves would appreciate that tremendously, and I think in many instances the only thing that keeps us back from really putting that into practice is the fact that there are not at present enough graduate nurses to permit us to do it.

MR. BRUCE: Is the Canadian Nursing Association making use of nurses supplied by the Red Cross and St. John Ambulance Association, and if so, to what extent?

MISS MUNROE: Yes, we have been using some. We have had V.A.D. help from the Red Cross and some help from St. John Ambulance, and in addition to that during the last few months we have been having civilian volunteers from the community civilian war work centre and they have all been helpful. The only drawback is that they will come, perhaps, one afternoon or two afternoons a week or two mornings a week, and we do not have any continuity of service from the same person, and that is one respect in which the paid war helpers are a distinct advantage over the volunteers.

MR. BRUCE: That does not apply to nursing aid supplied by the St. John Ambulance Association of which I know something. They can go on duty every day, not just a day or two a week; is not that so?

MISS MUNROE: A good many of the members of the St. John Ambulance Association also are women who are working in other jobs and they could only, perhaps, give a little bit of service, say in the evenings, and in the evenings we do not have many supervisors on duty, so in our situation we have not been able to use the St. John Ambulance people to the same extent.

MR. BRUCE: I see your point, of course; but I would like to say that in Toronto the St. John Ambulance Association does supply a number of nurses for the Christie Street Hospital, they are on duty there; and if the need for them is a great as you have indicated and if you made that known to the head of the St. John organization I am sure they could provide you with a good number.

HON. MR. MACKENZIE: Dr. Bruce is the head, himself.

THE CHAIRMAN: Miss Munroe, do the civilian helpers of whom you have spoken care for the patients?

MISS MUNROE: They do not give what we actually call nursing care; they help feed the patients and look after them, and they will assist the nurses in turning them and carrying out nursing care.

MR. BLANCHETTE: On page 3 of your submission the following statement is made: "Until recent years the nursing load was carried almost entirely by student nurses. This practice is unsound from the point of the student and the patient." Could the committee be informed if the hospitals in general are steering away from this custom, and what is the proportion of hospitals that are having the nursing load carried on by the students?

MISS LINDEBURGH: At the end of the paragraph it says: "Over 3,000 more graduate nurses are employed in general duty in hospitals throughout Canada to-day than was the case ten years ago." So there is evidence of a trend; hospital administrators are quite understanding, speaking generally, in regard to this situation in hospitals and in schools of nursing conducted by hospitals. I say in hospitals conducting a school of nursing, and it has to be realized that the care of patients cannot be maintained and adequately maintained by student nurses alone. We must look at this from the school

nursing point of view or from the educational point of view so that these students will become nurses, rather than being there as nurses. On the other hand, looking squarely into the situation, they are nurses, are they not? They are on the wards to-day. They are nursing patients and they are nursing patients under very careful supervision, because the welfare of the patient must be safeguarded. But in no case would they think of a first-year nurse, a young nurse, being given a very sick patient to nurse. If a student is to nurse those patients she must be a more advanced nurse in her training and still be under supervision; but with the very best of planning on a student basis still it is recognized that the nursing service in hospitals would be impaired and there would be definite hazards. Of course, it is only natural that hospital administrators are anxious that their hospital will be a good hospital and that the patients will be well cared for. However, the need for the graduate in the hospital is now recognized across Canada. It is amazing the change that has taken place. I heard a superintendent of nurses say—she has been in that position as an administrator probably for twelve years—she said: "When I came here there was not a general duty nurse on the staff and to-day we have 300." That is a large hospital. It is evidence that this is necessary for the care of patients in hospitals.

Mr. BRUCE: In regard to nursing schools and teaching schools for nurses in hospitals, is there any limit as to the size of the hospital below which you will not allow training schools—which have not the facilities for teaching nurses?

Miss LINDEBURGH: We have many good hospitals that are conducting schools of nursing but have not complete clinical facilities for the rounded-out experience as recommended in the undergraduate course, and in some cases those schools of nursing affiliate with other schools. For instance, there might not be in that general hospital a communicable diseases section or a child nursing section and the students of that hospital will go to some special hospital for two or three months where they will get their experience in pediatrics.

Mr. BRUCE: What happens in the case of the small hospital of fifty beds?

Miss LINDEBURGH: We have a definite recommendation that hospitals under 100 beds—that is our suggestion in the Canadian Nursing Association curriculum—should not conduct a school of nursing. Since the educational survey by Dr. Weir in 1930 quite a percentage of schools was discontinued in hospitals that could not even by affiliation secure sufficient clinical facilities for the education of the student nurses.

Mr. BRUCE: That is the point I wanted to bring out.

Miss ELLIS: Mr. Chairman, the provincial Act in each province determines the size of the hospital that may conduct a school; it is not controlled by the Canadian Nursing Association; it is under provincial control, and in many provinces it is far below 100 beds, but it is recognized that 100 beds is considered by the profession to be the minimum that should undertake to conduct a school, but in some cases hospitals with as few as 20 beds or 15 beds are conducting schools of nursing.

Mr. SHAW: On page 1 the brief states that the membership of the organization is 19,000. May I ask what percentage that would be of the total number of qualified nurses in Canada?

Miss ELLIS: I think that is a question, Mr. Chairman, that we cannot answer very accurately until the results of the present registration are made known. We have never had what we call a very satisfactory registration of nurses, so I would not like to undertake to state just what the percentage is. We hope to have that information in a very few weeks now. However, it represents quite a large proportion, I think, of the nurses who are actually practising.

Mr. SHAW: It states in the second paragraph that the association includes all registered nurses practising in Canada with the exception of those indicated

in Prince Edward Island and Ontario. Are we to accept that actually as it reads and conclude that all registered nurses in British Columbia, Alberta, Saskatchewan, Manitoba and so forth, are members of the Canadian Nurses Association? Is it obligatory that they be members of the association in order to practise as registered nurses?

Miss ELLIS: No, there is no compulsion regarding registration except in two provinces, Alberta and Saskatchewan, and there the Act states that nurses must not practise—a graduate nurse must not practise in a government-aided hospital unless she is registered, but by and large I think the registration is just as large in the other provinces where it is not compulsory because public opinion and the general trend of events makes it almost compulsory for nurses to be registered in order to be employed at all.

Mr. SHAW: Is it compulsory in Ontario?

Miss ELLIS: No, it is not compulsory, except in Alberta and Saskatchewan. Of course, hospitals are beginning to say: "If anything happens and our nurses are not registered what is going to be our liability?" And it is almost compulsory as far as the standpoint of the opinion of hospital authorities is concerned, but it is not as far as legislation is concerned.

Mr. MCGARRY: In the second paragraph on page 12 of your brief it states: "More recognition and assistance should be given to nurses working under many handicaps in outlying parts of the country." I would like to ask what the implication is there as to the source from which this assistance will be forthcoming. Does it mean from community welfare movements or from funds provided by federal and provincial governments in health insurance funds?

Miss LINDEBURGH: This is a very general statement. Looking at the situation of a nurse in a rural area we realize sometimes that she has to walk long distances when she should be riding. As you know, the horse and buggy stage still exists in the rural areas. Many nurses should have cars, and there are many areas where a car would not be of any use; but from the point of view of economy of her time there is something to be said, and from the point of view of the way she lives and the care of her own personal health. Nurses in rural areas are called at all times of the day and night. I was talking to a public health nurse not long ago who is in an isolated rural area. She said she had not had sleep for weeks because the community need was a continuous thing and she is called any time during the twenty-four hours for maternity cases. She is not sufficiently supported with personnel. There should be two people there where there is only one person. I am only just speaking in general terms. Then, from the point of view of facilities in clinics, people helping her to make a survey or to conduct health clinics, a lot of those facilities are restricted in the outlying parts. The rural population lives under handicaps in many ways, and they are so important to the economic and social structure of our country. Their health should be safeguarded in every way. This was simply a statement put in on behalf of nurses in rural areas so that possibly when we think of distribution of professional services throughout the whole of Canada we will realize the great necessity of improving health facilities in rural areas. Miss Hall and Miss Moore can speak of that situation.

The CHAIRMAN: Miss Hall, would you comment on that?

Miss HALL: Mr. Chairman, with regard to nursing in isolated communities we have had that experience in the Victorian Order. In certain isolated communities salaries for nurses are lower than they are in places where living conditions are much more attractive. I think the qualifications for a nurse in a rural community very often should be higher than they are in more closely populated centres because she is more on her own responsibility and much more depends on her judgment, but in spite of that the remuneration is not as high and conditions are not as attractive for a nurse to go there. We have very great difficulty

in filling vacancies in such areas. I think if through some means sums could be provided to bring about more attractive conditions for the nurses perhaps there would not be that difficulty.

The CHAIRMAN: Miss Moore, would you comment?

Miss MOORE: Mr. Chairman, Mr. Minister: I agree with all that Miss Hall has said. Such has been our experience, but I should like to say something about the attraction and the challenge of such service. We have been able to secure splendid nurses to undertake these difficult jobs, but we cannot ask them to remain long because the living conditions, in my opinion, perhaps present the greatest difficulty, and the general attitude of the community is that any sum of money is a large one.

Mr. COTE: Mr. Chairman, referring to page 13, the first paragraph I read:—

Routine hospital duties are in too many instances assigned to nurses, both graduates and students, which could and should be delegated to ward aides and helpers. It is apparent that the nurse's time should be conserved for the care of the patients, and non-nursing duties assigned to a lesser skilled and lower salaried worker.

Is it a fact that should the committee see that an adequate number of ward aides and helpers are provided in hospitals generally the number of graduate nurses actually serving the needs of these hospitals would be sufficient or about sufficient, and that, as a matter of fact, it is rather the scarcity of ward aides and helpers that we deplore? I would like to have some more information on that point.

The CHAIRMAN: Miss Munroe, would you please comment on that question?

Miss MUNROE: Just at present there is very definitely a shortage of paid ward helpers and ward maids, but I do not think that is the only thing that enters into the question. I think it is often the case that it is cheaper to have the work done by student nurses than it is with paid help, and therefore the hospitals have taken the cheapest way out.

Mr. SHAW: Probably three weeks ago I read a report written by one of the district nurses in an outlying area in one of the western provinces. This report was of such a nature as to almost bring tears to one's eyes. This young lady was apparently under a tremendous strain. About that time I asked what the Medical Procurement Board might be doing with respect to transferring doctors from smaller communities where we probably have three or four practising physicians to some of these areas that are absolutely without doctors of any kind. I think that action on the part of the medical procurement board probably would relieve much of the distress that is being encountered by the nurses who are trying to serve these rural areas. Could we have a report with respect to the action of the Medical Procurement Board in this connection?

The CHAIRMAN: Dr. Routley, would you comment, please?

Dr. ROUTLEY: Mr. Chairman, Mrs. Casselman, ladies and gentlemen: The Canadian Medical Procurement and Assignment Board was established by three orders in council dating back to July 7, 1942. The procurement and assignment board was originally set up to provide medical officers for the three fighting services while at the same time an attempt was made to keep a balance between medical needs of the armed services and the civilian population. As time went on it became apparent that the sister professions of dentistry and nursing had to be included in any comprehensive study of the health services of Canada, and therefore they were included within the composition of the board.

Now, sir, for the last several months an intensive survey has been under way in Canada to determine what our health resources and liabilities are. I should

perhaps put on record in answer to this question that committees representing the armed services, public health, nursing, dentistry, medical schools, hospitals, and the communities generally have been endeavouring to ascertain exactly what the needs of the country are, and how they can be met. It is anticipated within the next few weeks a comprehensive report will be made available through the Canadian Medical Procurement and Assignment Board and tabled with the government in respect to these findings. It will remain, Mr. Chairman, for the government, of course, to determine what, if anything, it shall do with the recommendations that may find a place in that report.

I am sure, sir, that one does not need to remind this parliamentary committee that the Canadian Medical Procurement and Assignment Board has no power or authority to place doctors, dentists or nurses anywhere. This is a time in the affairs of our land when, within certain limitations, people are obliged to do things, but beyond those limitations people still have their own freedom to move about as they see fit. Time and again I hear suggestions that the Canadian Medical Association or the Canadian Medical Procurement and Assignment Board had failed to move a doctor into an area. Mr. Chairman, may I say again we have no ability to move a doctor anywhere. We hope, however, that when all the facts are disclosed that methods may be found whereby our health resources will be disposed in Canada to the best interests of the Canadian people.

The CHAIRMAN: Are there any further questions before Miss Lindeburgh withdraws?

Mr. WOOD: Mr. Chairman, regarding rural service what method would be suggested to overcome the difficulties? Would it be by subsidy to the nurse in the rural sections or by periodical visits or encouraging the rural people to take advantage of hospitals?

The CHAIRMAN: Miss Moore, would you comment, please?

Miss MOORE: Mr. Chairman, Mr. Minister; there are many rural areas unserved, but in addition to the difficulties in connection with the nurses living there are problems of giving care in homes with lack of equipment. If I may refer to a study made in a small area in Ontario over a year ago, one of the questions in the survey was, "Was the home suitable for nursing care," and a very small percentage of the homes visited in the five townships—and all homes but three in the townships were visited—in the judgment of the nurse based on standards set for her—and very modest standards, I may say—were suitable for the giving of nursing care within the home. I think that has a bearing on the situation, and also the possibility of two nurses, as was suggested by Miss Hall, where there may be only one now, in order that they may have relief and companionship and the opportunity of discussing the situation, and certainly the nearness of medical advice and the health officials would have a bearing upon it also. Just how it might be made most effective I am afraid I do not know.

The CHAIRMAN: Thank you, Miss Moore; are there any further questions for Miss Lindeburgh.

Mr. McCANN: Mr. Chairman, I take it that the purpose of having asked the Canadian Nurses Association to present a brief before this select committee on social security was to have their views with reference to the proposed health insurance scheme. I think from their brief that they have re-acted favourably to that scheme. Having said that immediately one is of the opinion that there is a distinct challenge to the nursing profession as to whether or not they are in a position, or are going to put themselves in a position, to meet that challenge when the health insurance scheme is implemented. That is a challenge which is not peculiar to the nursing profession. It affects the medical profession; it affects the dental profession, and other services which will be called upon to

meet the increased demands when health insurance becomes an effective and active organization. I wonder what the nursing profession is doing, or what they intend to do, to meet that challenge. I have been identified with the profession for a number of years, and on close observation I can see there are a great number of difficulties which the nursing profession must meet in order to be in a position to meet the demands as they will arise increasingly in future years. I submit to this committee, Mr. Chairman, and to the nursing profession, that now is the time to prepare for that challenge. What are you doing to induce young women to enter the nursing profession? There are so many counter-attractions at the present time, other vocations which they may take up in which the hours of work are fewer, in which the hours for recreation are greater, in which the monetary return is greater. You cannot expect young women in this day and generation to have that degree of altruism which probably they had in years gone by which induced a fine type of young woman to enter the nursing profession. It has got to be made more practicable. They have got to be given better hours. They have got to be given greater inducements to enter the profession and they have got to be treated as women in a profession, not as maids in a hospital. That is exactly what is being done in too many institutions. Girls of good education who take up the nursing profession are put at work which is entirely foreign to their particular type. I know that the needs and the exigencies of the situation are such as to demand—and particularly in these times when so many nurses have gone into the armed services—that those who are left take on increasing duties. What is your problem? Is it money or is it people or is it both?

Miss LINDEBURGH: Both.

Mr. McCANN: I think it is both. I am going to suggest to the Minister that having made the grant through the Department of Pensions and National Health which he did last year to the nursing profession, that if he wants to be prepared and his department wants to be prepared to put health insurance into effect two or three years from now, that he, too, should be prepared as far as nursing is concerned, and in order to do that he will have to increase that grant two or three-fold this year and probably double it again the next year because it takes at least three years to prepare a nurse to go into active practice.

I submit to him that this committee ought to make a recommendation in its first report that in order to prepare the way for future years in having available the supply of competent nurses that will be needed when we put health insurance into effect that we should ask for a greater appropriation this year and in the years to come.

I know these are problems which the nursing profession as an organized body have perhaps taken into consideration, but I thought that this was a good time and a good place to say a word for the profession and to urge them that they place their needs before the proper authorities and tell them plainly and bluntly, "If you want us to take this on in two or three years now is the time to start, and if you will give us the money we will do the work."

Mr. KINLEY: Mr. Chairman, before we finish with this discussion I would just like to say a word complimenting the Victorian Order of Nurses in Canada. The Victorian Order of Nurses is doing splendid work and they have been for many years. The nurses are supported by the community in which they serve. They are controlled by the organization of the Victorian Order which is highly skilled in its management. In the outposts, in the communities where nurses are scarce, the Victorian Order nurse is the one who is bearing the load today. I think that the war troubles in the rural communities in so far as public health is concerned are made much lighter by the fact we have the Victorian Order of Nurses in the community. It is a voluntary organization supported by the public of Canada. The nurse's pay is set by the community

in which she serves. She serves people freely who cannot pay. If you can pay you pay a small charge, but it is a service that is given to everybody who needs it in a community and it is supervised by people who are alert and who are leaders of public opinion in these communities. It seems to me that in the study of our public health service we could very well look into the activities of the Victorian Order because that order is in the forefront of public health service and they are really the pioneers in the service which in the future of Canada we are all hoping will be better.

The CHAIRMAN: Miss Roy, director of nurses of the City Department of Health of Montreal, is here and we should like to hear from her.

Miss MARIA ROY, Called.

The WITNESS: The Association of Canadian Nurses was organized in 1908; it is the federation of provincial associations of registered nurses. They comprise a total membership of 19,000 in Canada, of whom 1,200 are Catholic nursing sisters and 1,960 are French-speaking lay nurses.

In each province, with the exception of Ontario and Prince Edward Island, the graduate nurse after successfully passing registration examinations and paying her fee, automatically becomes a member of the Provincial Association and by reason of that fact is also a member of the Association of Canadian Nurses.

The membership fee is renewable annually.

The national office of the Association of Canadian Nurses is situated in Montreal, at 1411 Crescent Street. The official publication is "The Canadian Nurse."

The members are divided into three branches: institutional service, general service and public health service.

Since the very inception of the Association of Canadian Nurses the object has been:

1. To promote national unity among the nurses.
2. To improve the nurses' standard of education and experience with a view to giving a better service to the public.
3. To stimulate among its members a keen interest for the well-being of the population.
4. To foster good understanding towards the nurses of other countries.

In every modern locality, nursing services are rightfully considered indispensable public utility services. It is beyond doubt that under health insurance nursing becomes an indispensable branch, and a wise and effective plan will be the responsibility of the registered nurses of the whole of Canada.

In every city registers or employment offices are organized in order to meet calls for nurses who accept to work in return for a daily remuneration. The registers are maintained out of the subscriptions of the nurses without any assistance from the community served. These registers will probably serve a wider purpose under health insurance. Hence, we believe that financial assistance will be necessary to ensure their existence.

PUBLIC HYGIENE AND VISITORS' SERVICE

This service comprises: house visits, school hygiene, industrial hygiene, instruction and prevention in respect of child hygiene, maternal hygiene, tuberculosis, venereal diseases and every other specialty in which health nursing has become an essential part of every public health program, as applied to a rural or urban community.

Health education and sickness prevention are the very foundation of every visiting nurse's program.

Hence, it is of the utmost importance in a health insurance program that, in addition to the provision of medical care and nursing for sick persons, steps be taken to ensure sickness prevention and the maintenance of health through education.

This entails a special preparation to discharge such an important task which should be emphasized. We are pleased to call attention at this point to the action taken by the government in 1942 in providing assistance for nurses who wished to perfect themselves in any branch of nursing.

The greatest importance must be attached to the preparation, experience and personality of the persons to be charged with the organization of such a service. The provincial nursing organizations are particularly fitted to recommend such appointments.

THE ASSOCIATION OF CANADIAN NURSES APPROVES THE PRINCIPLE OF THE HEALTH INSURANCE PLAN

Canada's nurses have been interested for quite some time in a health insurance program.

In 1935, the Association drafted a program, and in 1938, a brief was presented to the Royal Commission emphasizing the necessity of a nursing service as an integral part of health insurance.

The Association of Canadian Nurses is interested in and desirous of participating in any health insurance plan, provided the nursing interests are safeguarded and utilized to the greatest advantage of the beneficiaries.

The service of nurses, as set out in the bill, seems to leave to provincial organizations full autonomy and the privilege of organizing, administering and controlling the nurses and nursing.

We endorse the recommendation of the Canadian Hospital Council as being of vital importance.

That all political interference be banned from the organization of nursing.

ESSENTIAL FACTORS IN THE DIVISION AND STABILITY OF A SERVICE OF NURSES

The division of the nursing services in Canada becomes a serious problem when it is a matter of meeting the requirements of both the rural and urban population. The tendency towards the centralization of nurses in the cities and the lack of nursing services in the remote districts are accountable for the fact that a section of the Canadian population is unattended.

Were it possible to make living conditions more attractive in the rural districts and provide better remuneration for the services, the difficulties would not be so great.

It must be borne in mind that the isolated nurse has serious problems to solve: a grave illness and the impossibility to rely on medical guidance entails the assumption of great responsibilities.

In hospitals and in the field of public health, salaries are at minimum levels and in many cases the hours of duty are long and the task much too burdensome. These factors make for discontentment and discourage the staff with resultant instability of the services.

A high standard is required in the nursing services operating under a health insurance plan to ensure the well-being of the population and the staff.

CONCLUSION

This report, prepared hastily, has not been revised by the Executive of the Association of Canadian Nurses nor by the provincial associations.

Hence, it is desirable, if needs be, that provision be made for a further discussion of this project.

The Association of Canadian Nurses wishes to assure the Special Committee on Social Security that its members are ready to co-operate in the development of a plan that ensures the well-being and the health of the Canadian people.

The CHAIRMAN: Thank you, Miss Roy. Mother Allaire, chairman of the Catholic Hospital Council is also present.

Reverend Mother ALLAIRE, Chairman, Catholic Hospital Council, Health Insurance Committee, called:

The WITNESS: Mr. Chairman, members of the committee, I am representing here the nursing division of the Catholic Hospital Council.

The president of the Canadian Nurses Association has presented the various aspects of nursing in Canada, therefore the object of this brief is to set forth the special characteristics of nursing sisterhoods in the general field of nursing.

As the laie nurse, the sister nurse strives to secure better health for the people, she contributes her share to science in nursing, and moreover she devotes her whole life to nursing. This is her key-stone to higher achievements, and it enables her to better appreciate the beauty and seriousness of her vocation as a nurse.

The nursing sisters of the Catholic Hospital Council of Canada are registered nurses. They care for nearly 21,000 patients daily. Within the last twenty-five years the bed capacity in sisters' hospitals has trebled. When we consider that sisters' hospitals are little or not endowed, this should prove the generous contribution of the sisters to the welfare of sick people in Canada.

The contribution of the sisters goes also to nursing education. From 175 schools of nursing in Canada 75 are attached to sisters' hospitals, and the enrolment in these schools each year is approximately 5,000 nurses.

The philosophy of nursing in sisters' hospitals is different from that of other nursing institutions. This is due partly to the sisters' lives, to their methods of education for nurses and to their administration of nursing service, therefore, it seems advisable that in the set-up of health insurance, and in the Act which will govern its application, due consideration be given to sisterhoods engaged in nursing, and thus preserve, as much as possible, their present system of hospital nursing care and nursing education.

While the sisters who form the nursing division of the Catholic Hospital Council of Canada are active members of the Canadian Nurses Association, their situation in the general field of nursing is very much different from any other, therefore, inasmuch as hospital nursing is concerned, it seems to justify the need of representation on boards or councils which will undoubtedly serve as advisers to the commissions or the health departments which will administer health insurance.

I have made this as short as I could. The first brief was very well presented and detailed. I just wanted to show the special aspects of our hospital nursing and our schools of nursing. Thank you.

The CHAIRMAN: Sister Madeleine who represents the Catholic sisters' groups of the Catholic nurses is also present.

Reverend Sister MADELEINE OF JESUS, Ottawa, called:

The WITNESS: Mr. Chairman and distinguished members of the committee, I am very pleased indeed to endorse the contents of the submission made by the Canadian Nurses Association and presented by Miss Marion Lindeburgh. I also endorse the contents of Mother Allaire's report. Perhaps I could give a short endorsement as well. I should like to say I appreciate very much Dr. McCann's appeal for extra funds for our nursing education. I thought probably I should include that.

I wonder if I may say a word, just a very short word, with regard to the pioneer sisterhood of nurses, who were in fact the pioneers in nursing. In the seventeenth century the first hospitals, as we know them, were nothing more than just outposts. They have increased in size and number until now they reach from coast to coast. We have 705 Catholic hospitals plus 175 agencies carrying on specialized work. Furthermore, may I also mention the fact that in the regions, the outlying districts which were mentioned just now where it is difficult for day nurses and sometimes impossible for them to remain any length of time, we do find sisters in voluntary religious hospitals carrying on at these outposts dispensaries and often social work, oftentimes at great sacrifice, and it is for people of this group that I should like to say a word. I hope when health insurance comes into effect that they will be given consideration so that it will not impede their work but help them not only to continue but to expand their work of charity and mercy, because ultimately it will mean an improvement in the health of the people of our country. Thank you.

The CHAIRMAN: Are there any further questions? Dr. Heagerty, have you any further comment to make?

Dr. HEAGERTY: Not on hospitalization.

Hon. Mr. BRUCE: As a member of this committee and also as a member of the medical profession for many years, I should like to express a word of commendation to Miss Lindeburgh and her associates for the very fine presentations they have given us this morning and to assure her of the sympathy which we have for the work of the nurse. If there is anything we can do to see that their work is improved in the future, it will be done.

The CHAIRMAN: Thank you, doctor.

Miss LINDEBURGH: I should like to express on behalf of the Canadian Nurses Association our gratefulness in being invited to come here today. I should also like to express to you how grateful we are for your patient hearing this morning, and we do hope that whatever will be done will be done for the good of all the people of Canada. We thank you so much for this meeting this morning.

Mr. PICARD: I think it would be fitting for a member from Quebec to say a few words of appreciation of the work that is being done in our province by the different orders carrying on nursing. I mean the nursing sisters in the different religious orders who for a great many years have done this work. In Quebec for many years we had at the disposal of the population only the religious orders. Later on it developed and extended and we have now the lay nurses who carry on extensive duties throughout the province in many places where it would not be possible or practicable to have any institutions. Up to that time we relied in the province—up to fifty or sixty years ago—on the devotion of the religious orders. I appreciated very much this morning the presentations made by two French-Canadian nurses speaking in such beautiful English and expressing so nicely their appreciation of the program that is now before us. I thought it would be fitting to say a word of appreciation on behalf of the population of Quebec for the work being done now.

The CHAIRMAN: On behalf of the committee I should like to express our sincere thanks to the representatives of the various nursing associations for their statements this morning and to assure them of our sympathy. We shall not be able to meet again until after the recess, when we hope we shall have studied and read with care all the various representations made to us.

We shall adjourn now to the call of the Chair. Thank you.

The Committee adjourned at 12.45 to meet again at the call of the Chair.

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Canada. Social Security, Special Committee

SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

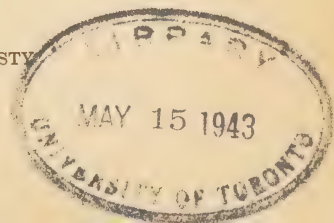
No. 8

FRIDAY, MAY 7, 1943

WITNESSES:

- Dr. A. E. Archer, President, Canadian Medical Council;
- Dr. William Boyd, Chairman, Department of Cancer Control, Canadian Medical Association;
- Dr. Charles Vezina, Dean of Laval University Medical Faculty, Quebec;
- Dr. G. E. Richards, Professor of Radiology, Toronto;
- Dr. Roscoe Graham, Professor of Surgery, Toronto;
- Dr. Carleton B. Pierce, Montreal;
- Dr. Louis Berger, Professor of Pathology, Laval University, Quebec;
- Dr. T. C. Routley, General Secretary, Canadian Medical Association; and
- Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health.
- Mr. H. M. Corbett, Creemore, Ont., and
- Mr. John Burgess, Toronto, Ont., representing the Canadian Pharmaceutical Association.

OTTAWA
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PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

FRIDAY, May 7, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Bourget, Casselman (*Mrs.*) (*Edmonton East*), Claxton, Cleaver, Donnelly, Fulford, Gregory, Johnston (*Bow River*), Lalonde, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGregor, McIlraith, Mayhew, Shaw, Veniot, Warren and Wood.—23.

Copies of the Advisory Committee Report on Health Insurance were distributed to the members.

Dr. A. E. Archer, President, Canadian Medical Council, was called. He introduced the following:—

Dr. William Boyd, Chairman, Department of Cancer Control, Canadian Medical Association;

Dr. Charles Vezina, Dean of Laval University, Medical Faculty, Quebec;

Dr. G. E. Richards, Professor of Radiology, Toronto;

Dr. Roscoe Graham, Professor of Surgery, Toronto;

Dr. Carleton B. Pierce, Montreal;

Dr. Louis Berger, Professor of Pathology, Laval University, Quebec, and Dr. T. C. Routley, General Secretary, Canadian Medical Association.

Dr. Boyd presented a brief on Cancer, and was examined by the Committee. The other above-named doctors and Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, were also examined by the Committee.

The Chairman thanked the witnesses and they retired.

Mr. H. M. Corbett, Creemore, Ont., and Mr. John Burgess, Toronto, Ont., were called. Mr. Burgess presented a brief on behalf of the Canadian Pharmaceutical Association.

The Chairman thanked the witnesses and they retired.

The Committee adjourned at 12.50 p.m. to meet again on Tuesday, May 11, at 11.00 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

May 7, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: We have this morning representatives of the Department of Cancer Control of the Canadian Medical Association. I would ask Dr. Archer, President of the Canadian Medical Association, to introduce the witnesses.

Dr. A. E. ARCHER: Mr. Chairman, Hon. Mr. Mackenzie, Mrs. Casselman, members of the committee, I have the honour this morning to introduce to you gentlemen who are members of the Department of Cancer Control of the Canadian Medical Association. They are as follows: Dr. Wm. Boyd, Chairman, Department of Cancer Control, Canadian Medical Association, and Professor of Pathology of the University of Toronto; Dr. Chas. Vezina, Dean of Laval University, who has been before you before; Dr. G. E. Richards, Professor of Radiology, University of Toronto; Dr. Roscoe Graham, Professor of Surgery, University of Toronto; Surgeon Commander Dr. Carleton B. Pierce, Associate Professor of Radiology, McGill University; and Dr. Louis Berger, Professor of Pathology, Laval University.

Dr. Wm. BOYD, called:

The WITNESS: Mr. Chairman, Mr. Minister, Mrs. Casselman and gentlemen of the special committee:

1. STATEMENT OF THE PROBLEM

Cancer has become one of the most important of the killing diseases, being surpassed in this respect only by heart disease. The great fall in the general death rate which has taken place during the present century is due very largely to mastery of the infectious diseases caused by bacteria. Cancer, on the other hand, presents one of the main unsolved problems which confront medical science. The disease is often accompanied by long periods of suffering and disability. The efforts of medical science are being directed with considerable success to improving the methods of diagnosis and treatment. An immense amount of research is being conducted on the profoundly difficult problems of the cause and the nature of the disease. For these reasons, the subject of cancer demands consideration in any scheme dealing with health insurance.

(1) *Cancer on the Increase.*

The death rate from cancer has been steadily rising. In the year 1926 this rate was 81 per 100,000 population in Canada; in 1941 it had reached 117. At the present time there are at least 50,000 cases of cancer in Canada, and about 13,000 deaths from the disease every year. Out of every ten adults, one will probably die of cancer. The actual figure may well be considerably higher, for in large hospitals post-mortem examinations reveal that many patients have suffered from cancer which was undiagnosed during life. Some of the increase, which has been observed in all parts of the world, is probably due to better methods of diagnosis and also to the fact that a larger percentage of the population is reaching a more mature age, for cancer is pre-eminently a disease of

advancing years. Thus the death rate is highest in Nova Scotia (135·6 in 1940) and in British Columbia (147·5), provinces in which the age composition is the highest. Part of the increase, however, appears to be real, although no satisfactory explanation for this can be given.

(2) *Cancer Control.*

The term cancer control, although in general use, is somewhat misleading. The disease cannot be controlled in the sense that smallpox, tuberculosis, and vitamin deficiencies can be controlled. Control implies prevention, and prevention is only possible when the cause and nature of a disease are understood. But the control of diagnosis and treatment is possible, and marked improvement in results has followed the organization of such control. The two basic requirements for this type of control are early diagnosis and early treatment.

In order to facilitate early diagnosis and early treatment, special efforts have been made everywhere by health authorities. For example, the Swedish government has established a cancer institute at Stockholm, which is recognized as a model for the rest of the world. Patients are brought to this institute from all parts of Sweden for treatment, the government paying for transportation where necessary. The radium used for treatment in the institute is provided by the government. During the years that the institute has been functioning, "five year cures" have been obtained in 38·5 per cent of all cases. It must be pointed out that this figure includes all cases of cancer whether early, late or hopeless. Similar schemes for facilitating early diagnosis and treatment have been instituted in Norway and Denmark. One of the chief reasons for the success of these schemes in Scandinavian countries has been the application of the principles of centralization and specialization. Other countries have come to similar conclusions.

(3) *Why Cancer Demands Separate Consideration*

It may well be asked why cancer should be separated off from the general group of diseases. There are several reasons. Cancer is a unique disease, its essential nature remains a mystery, and its cause or causes are still unknown. Treatment, if it is to have any chance of success, demands an unusual degree of organization, cooperation, and team work. Such treatment necessitates a highly trained personnel and the use of very expensive apparatus and materials, and may have to be carried on over a prolonged period. In no other disease is a follow-up system so essential, for this is the only method by which the ultimate results of various forms of treatment can be determined. In cancer, as in the case of no other disease, recurrence may take place years after an apparent cure has been effected. This is not a second attack, but an indication that the original disease has not been fully eradicated.

(4) *Methods of Treatment*

Cancer is at first a local disease, and while it is still local and accessible it is curable. Unfortunately by the time the disease is recognized it may no longer be localized. This delay in diagnosis is in part due to the doctor, who may not suspect that cancer is the cause of the symptoms of which the patient complains, and in part to the patient, who is unaware of the significance of his or her symptoms, or, being wrongly convinced of the hopelessness of the disease, is afraid to consult a doctor. Delay in treatment may be due to the expense of transportation to a treatment centre, or to reluctance on the part of the patient to give up work for a lengthy course of treatment for a lesion or pathological change which may appear to him to be trivial and insignificant. An adequate follow-up system is essential, not only to determine the results of treatment, but also to detect at the earliest possible moment any recurrence of the disease for which further treatment may be necessary.

At the present time there are only two recognized methods of dealing with the disease. The tumour may be removed surgically or it may be treated by means of radiation, the latter including radium and X-rays. Both methods demand for their success a high degree of specialization. This is true both of the radiologist and the surgeon. The surgical removal of a widely spreading cancer is a very different matter from the removal of an inflamed appendix, and powerful radiation is a dangerous weapon, except in the hands of an expert. Statistical analysis will show a remarkable difference in the final results of treatment carried out under the very best conditions as to highly trained personnel and specialized apparatus compared with those in which conditions are less favourable.

Specialized treatment can best be provided in cancer centres or cancer clinics. These centres will usually be developed in connection with existing hospital facilities, but separate institutions may be established, depending on local conditions which will vary widely. In these centres the most efficient forms of treatment and diagnosis are made available. They serve also as centres for the dissemination of knowledge regarding the disease, and it is here that advances are likely to be made in developing new methods of treatment. The average doctor in the course of a year sees few cases of cancer, whereas the men working in a centre see a large number of cases in the same space of time.

It is evident that early diagnosis and early treatment are and must remain the two basic principles of the management of a cancer case. When the house is threatened with fire, the two things you demand are, first, a fire department with efficient personnel and the best equipment, and second, prompt arrival of that department.

II. EXISTING FACILITIES IN CANADA

The various provinces of Canada have the following facilities for the diagnosis and treatment of cancer.

British Columbia.—The British Columbia Cancer Institute is a semi-voluntary organization receiving aid at the present time from the provincial government because of financial difficulties. A supply of radium has been provided by the government, but deep X-ray for purposes of therapy is not available. Cancer clinics have been formed in the Vancouver General Hospital and St. Paul's Hospital, Vancouver, and also in the Jubilee Hospital and St. Joseph's Hospital, Victoria.

Alberta.—In Alberta there are two diagnostic cancer clinics, one at the University of Edmonton, the other in the Holy Cross Hospital in Calgary. Free diagnosis and free treatment, both by radiation and surgery, are provided at these clinics.

Saskatchewan.—In Saskatchewan the cancer program is directed by the Cancer Commission. This commission has organized two clinics, one at the Grey Nuns' Hospital, Regina, and the other at the Saskatoon City Hospital. These clinics are not free, but if the patient is unable to meet the expense of diagnosis and treatment, the council of the municipality in which he resides assumes the responsibility for payment.

Manitoba.—In Manitoba cancer control comes under the jurisdiction of the "Cancer Relief and Research Institute," an organization set up by statute and subsidized by the provincial government. Two clinics are in operation, one at the Winnipeg General Hospital, the other at St. Boniface Hospital. Both come under the supervision of the institute.

Ontario.—In Ontario there are seven cancer centres situated in the following general hospitals; Ottawa General Hospital; Ottawa Civic Hospital; Kingston General Hospital; Toronto General Hospital; Hamilton General Hospital; Victoria Hospital, London; Metropolitan Hospital, Windsor. The provincial

government supplies radium on loan to these seven centres at an original cost to the government of about \$450,000. Special forms for recording data on cancer cases are supplied to the clinics by the Department of Health, and the data are summarized yearly by the medical statistician of the department.

Quebec.—In the province of Quebec, the fight against cancer is carried on by "l'Institut du Radium" of Montreal and the "Centre Anticancereux de l'Universite Laval" at Quebec, which were subsidized by the provincial government, and by several cancer clinics in the following teaching hospitals: the Royal Victoria Hospital and the Montreal General Hospital of McGill University, l'Hotel-Dieu de Quebec of Laval University and Notre-Dame Hospital of l'Universite de Montreal. The charge for treatment depends on the ability of the patient to pay. If unable to pay, there is no charge.

New Brunswick.—In New Brunswick there is a cancer clinic at the Saint John General Hospital.

Nova Scotia.—In Nova Scotia there is a cancer committee in connection with the Victoria General Hospital, Halifax. This committee sees patients sent in from the province and recommends treatment. The X-ray and radium facilities of the hospital are available for purposes of treatment. Treatment is given without cost to those who are unable to pay.

Prince Edward Island.—In Prince Edward Island there are no cancer clinics or similar organizations designed for the diagnosis and treatment of cancer.

Such, in brief, are the facilities throughout the dominion for the diagnosis and treatment of cancer. The chief criticism, if any, that could be made with regard to them is that they vary widely, depending largely on the ability of the various provinces to meet the cost of treatment. With a few exceptions, they represent unrelated individual efforts rather than organized groups. In several instances the facilities which exist are not adequate as measured by modern standards.

III. GENERAL PRINCIPLES OF ORGANIZATION

The Department of Cancer Control of the Canadian Medical Association through its executive committee and in consultation with representatives in the various provinces has given careful study to the question of cancer. As a result of this study the committee begs to suggest that the following general principles of organization should be considered:

1. The diagnosis and treatment of cancer should be included under the health insurance section of the National Health Act rather than under the public health section;

2. The health insurance section of the Act and/or the first schedule of the dominion Act pertinent thereto, should provide for the diagnosis and treatment of cancer and research on cancer to be sponsored by the federal government jointly with the provincial governments, together with the provincial medical associations, the medical faculties of the universities, and such hospitals and treatment centres as may be concerned. It may be considered advisable to set up a federal organization in addition to the provincial organizations recommended below. If such an organization were established, it should include representation from the National Research Council;

3. Cancer is a disease whose proper management requires centralization of diagnosis and treatment.

4. The federal and provincial governments should allow no financial, geographic or other obstacles to exist which might prevent any person from receiving early and efficient treatment.

5. A model plan for the management of cancer should be approved and incorporated either in the health insurance section of the bill, or in the regulations governing the administration of the bill under the titles of standards and conditions in paragraph 4 of the federal portion of the draft.

IV. RECOMMENDATIONS

With regard to such a plan, the committee wishes to make the following recommendations:

1. That cancer be made a reportable disease; such report to be made to the properly constituted authority of the province, and to include the means whereby the diagnosis had been made.

It is recognized that it is unusual to make a non-infectious disease reportable, since prevention is the final object of such a measure, and for the present cancer is not preventable. The committee feels, however, that real advance in our knowledge of the best methods of treatment depend on making the disease reportable, because the only scientific determination of the value of any form of cancer treatment is by a careful statistical analysis of the data. Large numbers of cases of cancer are diagnosed and treated every year all over Canada of which no accurate record of the final result is available. Many other cases are diagnosed and treated by non-medical methods, but under existing conditions it is impossible to appraise the real value of such methods. In order to obtain a complete picture of the cancer problem in Canada it is necessary that every case in every province, no matter by what means it is treated, should be recorded in some central office.

2. That adequate provision be made for the statistical analysis of cancer data. The paramount importance of the statistical method has been explained in the preceding section.

3. That the Provincial Health Insurance Commission establish an organization—

Mr. Chairman, we have not given any name to such an organization; we refer to it in future as an "organization"—

for the purpose of correlating all cancer activities and of receiving and analysing reports and data, and that the office of the medical statistician be attached thereto.

4. That this organization should include a representative named by each of the following: each medical school of the province; the provincial medical association or associations; the Department of Health of the province; and subsequently by each of the cancer treatment centres approved by the above-named representatives.

It is apparent that a certain amount of latitude must be allowed to the various provinces on account of the different conditions which may exist throughout the country.

Functions of Provincial Organization

The general functions of such an organization to be appointed by the Provincial Health Insurance Commission should be as follows:

- (a) To advise as to the organization of diagnostic and treatment centres for cancer and the personnel thereof;
- (b) To assist these centres in the treatment of cancer by means of funds, radium and equipment;
- (c) To arrange through the Provincial Health Insurance Commission provision for clinics and other diagnostic facilities, including the outlying districts;

- (d) To receive grants, gifts and bequests, and to administer all funds received;
- (e) To concern itself with the problems of the transportation of patients who live at a distance from a treatment centre;
- (f) To participate in a program for the education of the medical and nursing professions, education of the public being developed in collaboration with the Canadian Society for the Control of Cancer, which, I may explain, Mr. Chairman, is a lay organization already existing;
- (g) To foster research in cancer, more particularly in respect to clinical and technical problems;
- (h) To ensure that suitable facilities are provided for (1) convalescent hospitals, and (2) hospitals for incurables, the number, size and location of these to be determined by the individual province;
- (i) That under the regional medical officer provided for in section 44-3 (e) of the drafted bill there should be personnel (social service, nursing or secretarial) whose duties it would be to obtain such information relative to cancer patients as might be required by the provincial organization on cancer, and in general to act in liaison between a cancer patient, his physician, and the central office or treatment centre;
- (j) To be responsible for the organization of a bureau of investigation of alleged cancer cures. This might be operated as an activity of the federal government, somewhat along the lines of the existing arrangements for investigation under the Food and Drugs Act.

The CHAIRMAN: Thank you, Dr. Boyd. Are there any questions?

Mr. CLEAVER: I have two short questions. Dr. Boyd, on page two of your presentation under paragraph two, Cancer Control, the second paragraph of that section, would you please indicate what you mean by five-year cures?

Dr. BOYD: You will appreciate, Mr. Chairman, that some of these questions can be answered more appropriately by my colleagues, the surgeons and the radiologists, but I think I can undertake that myself by saying that unlike most diseases we can never be certain of the final result in the treatment of cancer. As I have indicated it may recur years later. By five-year cures we mean that at the end of five years the patient is apparently in perfect health as regards his disease. In other words, he is apparently cured of his disease. I do not know, Mr. Chairman, if any of my clinical colleagues would care to amplify that or not.

Mr. CLEAVER: Then, Mr. Chairman, my other question refers to a statement on page nine:—

It is recognized that it is unusual to make a non-infectious disease reportable.

Is it recognized that cancer is non-infectious?

Dr. BOYD: To the best of our knowledge at the present time it is non-infectious.

Mr. CLEAVER: Thank you, doctor.

The CHAIRMAN: Dr. Richards, would you care to comment on the first question?

Dr. RICHARDS: I think, Mr. Chairman, that Dr. Boyd answered that fully. A five-year cure means that at the end of five years the cases of cancer are alive and well without evidence of disease. That method of indicating results is recognized and used throughout the world by statistical bodies.

Mr. CLEAVER: Does that imply that it takes five years of treatment to reach that condition or does it mean that five years after the treatment the patient has been examined and appears to be cured?

Dr. RICHARDS: Mr. Chairman, it implies that five years after the completion of treatment and the apparent cure of the disease the disease still remains cured.

The CHAIRMAN: Dr. Graham, would you care to comment?

Dr. GRAHAM: To clarify the words "five-year cure" certain statistical reports speak of them as five-year survival rates.

Mr. VENIOT: Mr. Chairman, in order to shed a certain amount of light on the cancer problem while we have here the members of the cancer committee who can give us the information required I should like to ask five or six questions which are very brief.

First, what forms of cancer are suitable for treatment by surgery?

The CHAIRMAN: We will take each question by itself.

Mr. VENIOT: Yes.

Dr. BOYD: Mr. Chairman, may we have Dr. Roscoe Graham answer that question?

Dr. GRAHAM: Mr. Chairman, the types of cancer which are amenable to surgery are undoubtedly those that are not superficial, and particularly do they involve the lung, bowel, stomach and the deep lying tissues about the biliary apparatus. The breast is combination therapy, but surgical treatment alone is our sheet anchor in gastro-intestinal and pulmonary cancers.

Mr. VENIOT: What forms of cancer are suitable for treatment by radiation?

Dr. RICHARDS: Mr. Chairman, Mr. Minister; the field of radiation therapy really falls under three heads. First, there is the group of diseases in which radiation alone is utilized for the purpose of cure. This includes groups such as cancer of the lip, mouth and the throat. Some of these are treated in combination with surgical methods but more and more are coming to be radiological problems. Secondly, there is cancer of the uterus, and in the third group superficial cancers of the skin and certain types of cancers of the breast. Then in the second group there are types of cases which are treated in combination with surgery. Dr. Graham has referred to some of those, the breast, and in general many types of cancers which have not or cannot be completely removed during surgical operation. In the third place radiation has a very large part to play in which the object of treatment is palliation, relief of pain, prolongation of life; in this regard it has a very useful place. In other words, it is felt to be the function of therapy to cure cancer if that is possible, but if that is not possible, to make the patient's life as comfortable and free from suffering as possible, and in this field radiation therapy plays a large part.

Some statistics recently released in England by the National Radium Commission have shown that of all cases of cancer being treated slightly over 50 per cent are suitable for radiation therapy in some form or at some stage of the disease.

The CHAIRMAN: Thank you, doctor.

Mr. VENIOT: What can be done in the way of educating the public with regard to cancer treatment?

Dr. BOYD: I think Dr. Vezina could answer that question.

Dr. CHARLES VEZINA: Education of the public is one of the most important factors in the battle against cancer. If we wish to cure cancer it must be treated at the outset when it is localized. Even though we have very proficient surgeons and radiotherapists and powerful and highly perfected equipment, if the stricken person puts off a consultation until the cancer has become generalized in his system, there is nothing that can be done. Consequently, the public must be educated by teaching them the early signs of the various cancers and insisting that they go and consult a doctor. Doctors and nurses must perform this educational work.

There must be removed from the minds of the stricken persons the idea that cancer is an incurable ailment.

We organized an anti-cancer week in Quebec some years ago. It took the form of public addresses, radio talks, tracts, exhibition of anatomical pieces of the various cancers, statistics, etc.

We are of the opinion that following this educational week, the sick persons consulted doctors more quickly.

Hence, such campaigns designed to educate the public should be conducted often.

We are certain that it is one of the very important factors in the battle against cancer.

Mr. VENIOT: The next question is what types of cancer research can be carried on in Canada.

Dr. BOYD: We can divide cancer research into two main groups. The first is what we might call the academic or fundamental type. That is to say, laboratory investigation into such fundamental problems as the cause of cancer, the nature of cancer. That is the type of work which is done best, I believe, in connection with universities. The other type of research is what we may call clinical or applied research, which is extremely important and which consists in working out new methods of treatment and improving existing methods, both surgical methods and radiation methods. That can be called the clinical or applied type. That is the type which can be done so well in a cancer centre where there are large numbers of patients and highly trained specialists.

The CHAIRMAN: Dr. Boyd, is there extensive cancer research in Canada at the present time?

Dr. BOYD: No. In some of the universities there are certain researches and the late Sir Frederick Banting was much interested and devoted much of his time before the war to investigating cancer, but I think I can say no.

Mr. VENIOT: Does Dr. Boyd think that the medical profession requires education in the early diagnosis of cancer?

Dr. BOYD: I think Dr. Carleton Pierce might well answer that.

Dr. PIERCE: Mr. Chairman, Mr. Minister; my answer is yes, with the following comment. First the majority of cancer cases, with relation to giving them treatment at centres where definitive treatment can be given, are in the late stages of the disease. This can be interpreted and quite often is factually established as due to the fact that the diagnosis has not been made. Of course, to a certain extent the lack of patients visiting their physicians in order to discover such, even though they know something is wrong, plays a part in that, but many cases are treated for something else. That is particularly true in cancers of the intestinal tract, in the stomach, where the symptoms are oftentimes very vague. Very careful examination and thorough study by individuals aware that such symptoms might be caused by cancer should be carried on.

Then, many small tumours, tumours which the layman or the uneducated physician might pass over or consider as relatively insignificant, are more dangerous because of the fact that they are oftentimes associated with distant and dangerous metastases, dangerous spread of the disease, whereas with a large tumour the patient and physician might well be aware of the situation. Thirdly, it is essential to advise the patient relative to possibilities of prevention, early inspection care particularly in women, and also in order to learn how to recognize these very early changes and to decide as to whether or not he is competent to examine and attempt a diagnosis or whether he should seek more specialized consultation.

The CHAIRMAN: Thank you, Dr. Pierce.

Mr. VENIOT: Why is the problem of transportation of cancer cases, as referred to on page eleven, of particular importance?

Dr. RICHARDS: Mr. Chairman, one of the reasons for the success of the cancer organization in Sweden has been the fact that adequate provision was

made for getting patients to cancer centres early and returning them as frequently as might be necessary for observation and follow-up. In Canada distances are frequently great. In very many cases patients put off seeking advice because of the expense involved in going to a centre, and then after treatment has been completed there is the greatest difficulty in getting patients back frequently enough to be certain that the disease is under control or to recognize recurrence if it takes place, to recognize it early at a time when it can also be treated with some hope of success. From our own experience in Ontario I would say that there is no part of the cancer problem which needs solution to a greater extent than the problem of ensuring that there is no difficulty because of difficulty of transportation between the patient and the treatment centre.

Mr. VENIOT: In the brief just presented, Mr. Chairman, recommendation is made that diagnosis and treatment of cancer should be included in the health insurance section of the Bill rather than in the public health section. What is the particular reason for this recommendation?

Dr. BOYD: Mr. Chairman, at the present time in Canada public health is used to signify prevention of disease. We have seen in the press that the time has not yet arrived for prevention of cancer with, perhaps, one or two very minor exceptions; but it is true that some diseases are treated, properly under public health authorities, but these are diseases in which treatment, successful treatment, is necessary for prevention. Let us consider tuberculosis; one of the best methods for preventing tuberculosis is to treat the existing cases which serve as the focus of infection for fresh cases, but that does not apply to cancer at all. There is the example also of mental diseases which are properly treated by public health authorities. The mental disease is in a class by itself because of the relation of the mentally unsound patient to his neighbours; he can be a danger to those neighbours. That does not present itself in the case of cancer; the problem of cancer is above all the problems of treatment—diagnosis and treatment—and we feel—my committee and all the representatives of the association in the various provinces feel that that is best served by the health insurance section in the public health sections of the bill.

Mr. VENIOT: Why is centralization in the treatment of cancer desirable?

Dr. BERGER: Mr. Chairman, I believe that centralization is highly desirable in view of the complexity of the problem and the consequent role which has been emphasized by previous speakers. We have first the educational campaign. This should be undertaken in the light of observations in large numbers of cases and large numbers of cases may only be furnished by large organizations. Then we must consider it from the clinical point of view and there men of wide experience are needed in view of the difficulty of cancer detection. Then there is prognosis, and we should envisage biological services, that is diagnoses made of tissue samples taken from patients. Now, the pathological training is quite long, and I do not think there are many pathologists in Canada. In view of the scarcity of men it is also desirable that there should be quite intensive centralization.

The next point is treatment—surgical, X-ray and radium. The surgical treatment of cancer is not quite like common surgery; I believe it calls for specialized needs, more delicate technique than the usual surgery, and therefore some surgeons should be educated especially for the treatment of cancer; that is there should be specialization. Now, with regard to X-ray we need high voltage operators,—not merely 200,000 volt or 400,000 volt or even 1,000,000 volt, but as one gentleman said, 2,000,000 and 3,000,000 and 4,000,000 volt operators. That is very expensive and calls also for highly specialized personnel. I do not believe that small centres can bear the expense nor have they the necessary personnel. The same thing is true with regard to radium. With regard to the expensiveness of radium this is going down just now. The technique of radium is

quite difficult. There are many methods of radium administration. There is also the question of utilization of emanation which cuts the costs down and which is indicated in some special cases. Small centres certainly cannot obtain utilization of emanation; it should be done by some special specialist physical department which one generally finds in large institutions like universities. Now, there is the question of research. Research today, that is broad research on cancer, needs teamwork. Small centres would find great difficulty in having teamwork which is necessary to conduct the research. There is need for a large staff as Dr. Boyd has emphasized. There are two factors: academic which can only be dealt with in a liaison way with some university centres; and then there is the practical clinical work which calls for highly specialized personnel. I do not think centralization excludes such smaller centres. For instance, they could exploit existing facilities and make use of existing cancer or tumour clinics.

Mr. VENOIT: This is my last question: why should special hospitals be necessary or desirable for convalescents and for incurables connected with cancer?

Dr. RICHARDS: Mr. Chairman, may I make a comment in answer to this question which applies also to the last question. It has been stated in the brief that cancer is a unique disease. It is unique in one respect, and that is that a patient who is under treatment for cancer has about one chance for a successful outcome with this treatment. He may have two, but if the first or second are unsuccessful he will seldom be cured; therefore, it is utterly essential that the first steps undertaken shall be the correct steps and that, in my judgment, is perhaps the chief argument in favour of centralization, where a patient comes under the care of an expert and a highly skilled staff. The records show that patients who have been unsuccessfully treated elsewhere and come to centres for treatment have a very much smaller percentage of cures than those who are treated primarily by the centres from the beginning.

The same remarks apply to the need for hospitals for convalescents. This applies to patients who come from a distance to a centre. The first stage of the treatment is completed and then the patient should be kept under observation in a proper environment and usually under the observation of the staff of the treatment centre until it can be seen that his treatment is controlled or is likely to be controlled. This may require from one to two months or it may require three months, but if during that period the patient has returned to his home miles away and symptoms arise which require immediate treatment, the opportune time for such treatment may be lost. Such hospitals need not be large for a treatment centre seeing 1,000 new patients in a year—a convalescent hospital of thirty to fifty beds would be sufficient.

Finally, the question refers to incurable cases of cancer. The most pitiful thing in the world is a patient who is faced with cancer which is incurable and may be painful, and it is the duty of those who are providing organization for the treatment of cancer to provide facilities so that that patient will be cared for smoothly and kindly and skillfully, so, at least, if he cannot be cured his last days will be made as free from suffering as is humanely possible. At the present time facilities for this type of medical treatment are inadequate. I think that applies to practically all parts of Canada.

The CHAIRMAN: Is it possible adequately to account for the increase in fifteen years from 81 per 100,000 of population in Canada to 117 per 100,000, as appears on the first page of the brief?

Dr. RICHARDS: Mr. Chairman, I think Professor Boyd answered most of that question. I am speaking now from memory, and I cannot give you a more exact quotation, but an article was recently published by either the Metropolitan Life Insurance Company or some other large body studying cancer who have made a prediction of the future increase in cancer and have predicted that it will continue to rise until about the year 1960 or 1970 when, in spite of the efforts

of the medical profession and governmental organizations, it will still be at a higher level than it now is. Most of this increase is due to the fact that the composition—the age composition of the population is rising and growing older and becoming more stable. It is true that that does not explain the whole increase, and I believe that there is an actual increase in the incidence of cancer itself for which, I am afraid I have no explanation.

The CHAIRMAN: Thank you, doctor.

Mr. CLEAVER: Doctor, may I ask a question and then another question arising out of the answer given to Dr. Veniot's fourth question. The answer was that research work should be carried on as to the cause of cancer, and my question is: is the incidence of cancer peculiar to certain specific groups or individuals having reference to their occupation or type of employment; also, has heredity any bearing as to the incidence?

Dr. BOYD: I hear the clock striking twelve, and a member of the committee has asked a question about heredity. I shall try to answer the first question. The answer is yes, with respect to the relation of certain occupations to cancer of specific organs. Workers in the anilin dye factories suffer from cancer of the urinary bladder to a higher per cent than is the case of the general population. The reason is that the dye is absorbed and is excreted in the urine; it gets in the bladder and causes cancer. I could give you many instances. One of the most famous instances is cancer of the lung which is extremely common in a certain mining industry in Bohemia—or what used to be called Bohemia; I do not know its present status—a large percentage of the deaths there have been known for 400 years to be due to a wasting disease associated with some change in the lung. It used to be thought to be tuberculosis; now it is known to be cancer, and therefore that is an occupational disease.

Mr. CLEAVER: Doctor, as to these occupational causes of cancer, public health bodies would be very directly interested in trying to improve methods of carrying on these trades which are apt to cause an increase in cancer, would they not?

Dr. BOYD: Yes, there are instances where prevention can be practised.

Mr. CLEAVER: Would you mind answering the other half of the question with regard to heredity?

Dr. BOYD: Mr. Chairman, I would rather not answer that question; it is too difficult.

Mr. FULFORD: Mr. Chairman, there is no treatment for cancer patients in the various provinces such as there is for tuberculosis. Strangely enough just before the Easter recess a case was called to my attention of a farmer who had been sent to the Kingston General Hospital as an indigent patient by the township in which he lived. He was suffering from cancer of the rectum. After receiving a certain number of treatments, the parish refused to pay for any further treatment although he was not cured, and it would have been necessary to send him to the Leeds county poorhouse had it not been for a group of his friends who rallied around him. They could not afford to keep him at the Kingston General Hospital, but they did try to make what are apparently his last days a little more comfortable and they provided enough money for him to be boarded out at a farm house. I went twenty miles out of my way last Tuesday to see this poor fellow, and let me tell you, Mr. Chairman, that anyone who has seen a chap in the last stages of desperation, death facing agony, and suffering the torments of the damned, certainly has driven home to him the necessity that we in this country provide treatment for those who cannot afford to take treatment. I believe that in a case like that the township should be compelled by law—

whether provincial or dominion, I do not care—to see that that chap is kept at the hospital until he is either cured or pronounced incurable. If he is curable provision should be made for his care and he should not be sent to the poorhouse.

Dr. HEAGERTY: I should like to clarify one point and that is on the question of treatment. Every insured person would be entitled to treatment for cancer. The only reason that we made special provision for tuberculosis and mental diseases is that these diseases require prolonged treatment. We felt that we might exclude those cases requiring prolonged treatment from the provisions of the draft health insurance bill, by providing special grants to the provinces who would take care of them. But no such provision has been made in the case of cancer, so that every insured person will be entitled to treatment for cancer. The one difficulty I see that confronts us is that of incurable cancer, where it is necessary to keep the person under treatment for a prolonged time, for a year or longer. In that case the fund might not be able to bear the cost; it is only the question of the fund in so far as mental diseases and tuberculosis are concerned, so that there really is not any need to transfer the cancer section from the third schedule on page 43, which reads as follows:—

To provide aids for early diagnosis through hospitals and clinics and other accepted media; and to cooperate with voluntary agencies in an educational programme.

Now, money to be provided under that heading was for the purpose of controlling or prevention and control and not for treatment. We hope there will be ample money there for treatment. However, the suggestion made by Dr. Boyd was a repetition of what was brought forward at the meeting of the general council of the Canadian Medical Association, to the effect that special provision should be made in the section dealing with health insurance; and I believe myself that the day has arrived when we should recognize the responsibility of the dominion for certain national health problems. We have not reached that stage as yet; Canada has never taken responsibility for maternal or infant deaths or tuberculosis or mental disease or for cancer, yet these are national public health problems. I would suggest to the committee that they take into consideration the suggestions that have been made by Dr. Boyd and his associates, and that whatever recommendations are thought fit to be made be placed before the Advisory Committee on Health Insurance for our consideration and in fact that we have a thorough discussion of this entire question.

Mr. JOHNSTON: I understand from Dr. Heagerty—he emphasized it on two occasions—that just those who paid in their insurance would come under the treatment for cancer. If that is true then I think we are very far from our intention of social security, because unless this treatment applies to all individuals suffering from cancer it is going to depend entirely on a person's financial status. That, I think, would be wrong. I should like to have the doctor clear that up.

Dr. HEAGERTY: Provision is made in the draft bill to include everybody, as you know; that is, under section 2 of the draft provincial bill. The provinces may bring in everyone; they may bring in the rich, they may bring in the poor. If they do then all will receive treatment for cancer and any other diseases, because they would all be insured persons. Now, perhaps not all the provinces would wish to bring in all persons within the province. We want them to; we would like to see them brought in; we want them brought in. But the question is one that has to be decided to a considerable extent by the provinces, by the professions and by the commission, but the provision is here for the treatment of everyone.

Mr. JOHNSTON: I have one other question I should like to ask, which arises from the statement which appears on page 9 about three-quarters of the way down in the middle paragraph, which is as follows:—

Many other cases are diagnosed and treated by non-medical methods, but under existing conditions it is impossible to appraise the real value of such methods.

What are those other non-medical methods?

Dr. BOYD: In the course of the years one hears about and reads about methods which have been introduced by others than those in the medical profession which are hoped to produce satisfactory results in cancer. Sometimes one hears of a result which may appear to be very satisfactory, but it is felt that there may be very large numbers of very unsatisfactory results. One does not hear of them, and it is felt that by having all such cases recorded and the data collected in the central office that it will be possible particularly for the organization suggested in the very last of the recommendations in this report to determine if there is or is not anything good in such methods. The two methods which have been described in the brief are surgery, that is to say, removal of the tumour by the knife; and radiation. Non-medical methods would be other methods.

Mr. SHAW: Mr. Chairman, probably my question should be directed to Dr. Heagerty, but in view of the fact that through medical methods we have not yet an effective cure for cancer, would it be the purpose of the government under a health insurance scheme to encourage every non-medical method of treatment that might offer the slightest ray of hope in this connection?

Dr. HEAGERTY: Mr. Chairman, ladies and gentlemen, of course, the most important thing is the diagnosis, and the difficulty that confronts non-medical men is the diagnosis. It is rather unfortunate that so many persons who do not use the accepted methods of treatment are unable to diagnose and therefore the patient dies.

Mr. SHAW: I recognize, doctor, there would have to be the greatest precaution exercised in permitting others to experiment, if we may use that term, but nevertheless we are passing through changing times and we never know from the scientific point of view what might come to pass, and I think we should encourage every person or group of persons who may believe that they have some method that may prove satisfactory in connection with the curing of cancer. I say that particularly because we have not yet effected a cure for cancer.

Dr. HEAGERTY: Do you mind if I just follow that up? Each year we in the Department of Pensions and National Health receive applications for registration of patent medicines for cancer cure. Many of them are brought forward, so many of them are so worthless that we do not pay very much attention to them; many situations developed where it was necessary for someone to make an investigation to ascertain whether there was anything in any of those so-called reputed cures, with the result that a cancer commission was established in Ontario. You know more about that than I do, Dr. Boyd, and quite a number of cancer remedies were investigated, and all of them were found to be worthless. The medical profession has to be extremely careful in considering all those remedies that are brought forward because not yet has one of them been found to be of any value whatsoever.

Dr. BOYD: I should like to add one point. The speaker has said—and there is some truth in it—that there is no cure for cancer, but there is also, ladies and gentlemen, even greater proof in my statement that there is a cure for cancer. The gentlemen who are sitting in the front seats to-day are curing cancer every day, and anyone who has the privilege of attending follow-up clinics, which I am more familiar with in Winnipeg than in Toronto, is delighted on seeing patients coming back year after year cured. I feel that is a very important thing,

Mr. Chairman, to make clear to non-medical members of this committee, because I find in conversations with my non-medical friends in the world that they won't really believe it; they think we are trying to slip something over. If they could come to one of these follow-up clinics and see patients coming back with a smile on their faces, patients who had cancer of the tongue, cancer of the lip, cancer of the breast, and cancer of the uterus, and now they are all gone. It is wonderful; it is most encouraging when a patient comes in with a cancer—it may be in the curable stage, that is to say, the stage which is curable either by surgery or radiation, if he comes to someone who is employing one of the non-medical or non-recognized methods months may pass by on what my friend called experimentation without results. He then comes to the surgeon or the radiologist and it is too late and we have this terrible picture of the patient dying of cancer of the rectum, sir, suffering the tortures of the damned because that priceless time has been missed.

Mr. WARREN: Reference was made to investigation by provincial authorities into so-called cancer cures. Did that include plasters? We have had a good deal of experience with these plasters used in Renfrew county with apparently a good deal of success. I do not know that they are used so much now, but when you see the cases, seeing is believing, and I wonder if these plasters were included in the inquiry into the so-called cures.

Dr. HEAGERTY: I do not recall any plasters brought forward at that time; they were more modern in many respects. They consisted of serums or vaccines or something of that kind.

Mrs. CASSELMAN: In recent years there has been a campaign conducted along the lines of education—lectures and formations of lay committees. Has that been done under this Department of Cancer Control of the Medical Association or some other body?

Dr. HEAGERTY: Society of Cancer Control.

Dr. ROUTLEY: Mr. Chairman, answering Mrs. Casselman I perhaps can say this: the Canadian Society for the Control of Cancer was organized by the Canadian Medical Association on the recommendation of the trustees of the King George V Silver Jubilee Cancer Fund for Canada, and the society, while substantially a lay body, has the official endorsement of the organized medical profession of Canada. The society endeavours to carry out an educational programme primarily with the laity but with medical cooperation designed to give to the public the truth about cancer.

Mr. BLANCHETTE: Is Dr. Boyd able to inform us of the total amount of annual grants being given by the governments presently, either the federal government or provincial governments, for the control or cure of cancer?

Dr. BOYD: No, sir, I have not been able to get that information in the time at my disposal. Possibly someone else may be able to answer that question.

Mr. MACINNIS: The question I want to ask is related to the question asked by Mr. Cleaver earlier. Has there been any research made or any statistics available as to the incidence of cancer among the various income groups in the population?

Dr. BOYD: Mr. Chairman, the questions are getting difficult because cancer is a variety of diseases, I believe, rather than one disease. Cancer of the stomach is one disease, cancer of the breast another disease, and so on. But I can answer your question with regard to cancer of the stomach. Investigation in England some years ago showed that there is a relationship between cancer of the upper part of the digestive tract, from the mouth to the stomach, there is relationship between that and social and financial status; that the population was graded into five grades with the dukes at one end and the stevedores at the other end, and that was the grading of the incidence of cancer in the upper part

of the digestive tract. It was least in the most favourable class; it was highest in the least favourable. But when we came to the cancer of the intestines, there was no difference, so you will see how difficult it is to answer your question in one sentence. It may be true also of cancer of the skin, but not true of cancer of the brain.

The CHAIRMAN: Are there any further questions before Dr. Boyd withdraws? The committee is deeply grateful to Dr. Boyd, Dean Vezina, Dr. Richards, Dr. Graham, Dr. Pierce and Dr. Berger for the very illuminating and valuable statements with regard to cancer. I thank you very much, gentlemen.

We have two representatives of the Canadian Pharmaceutical Association. I shall now ask Mr. Preston to introduce Mr. John Burgess.

Mr. PRESTON: Mr. Chairman, Hon. Mr. Mackenzie, Mrs. Casselman and gentlemen, on behalf of the Canadian Pharmaceutical Association we wish to thank you for the opportunity of being present this morning. Accompanying me is Mr. Corbett, Registrar-Treasurer of the Ontario College of Pharmacy, who until recently occupied the position which I now hold, and Mr. John Burgess, who is our chairman on health insurance. He will present our brief.

Mr. JOHN BURGESS, *called*.

The WITNESS: Mr. Chairman, Hon. Mr. Minister, Mrs. Casselman and members of the committee, we thought that we should recognize the honour that you have shown us in asking us to present a brief before you by preparing our statement in considerable detail, which we have done, in certain mimeographed copies which are now on the table. I shall now present the brief.

(1) In presenting a brief on behalf of the Canadian Pharmaceutical Association, it is not unlikely that I may disappoint you in some fashion. Because as legislators in contemplation of possible enabling legislation, you are concerned at the moment with principles, and broad outline; with forms of administration and means of applying through the facilities of governments, the hoped for benefits to the mass of people of Canada—questions upon which your constitutional lawyers, your sociologists, and your men and women of special training in administration of this kind, are likely to provide you with better advice.

(2) I am not provided with any directive from the provincial pharmaceutical associations, nor from the Canadian Pharmaceutical Association to discuss these matters in detail. The small number of representative pharmacists who have seen and read the draft Act before you, have not recorded with me their reaction to that experience. Since no significant criticism of its method and tenor has come in from them, one may, I believe, take it for granted that if the legislators in their wisdom deem it wise and necessary to enact along these lines, the pharmacists have not yet seen any reason to question the general form of the plan proposed.

(3) Since the pharmacists are naturally to be entrusted with duties of no less importance than the placing at the use of patients all the tools of medicine—drugs, medicines, materials and appliances for the maintenance and restoration of health in so far as the processes of nature and the will of the Creator make that end a possibility to mortals—and since they are naturally expected to perform this service in every town and village and city of our wide extended nation, they will naturally anticipate that the people of Canada, in their own interest, will wish to have the pharmacists suitably represented upon the administering commissions, and to utilize their already admirably organized statutory provincial bodies for the purposes of consultation, cooperation and advice.

(4) But if I am ill equipped, and undirected to make recommendations in the purely legislative field, it may be useful to review some of the basic

facts about the position of pharmacy in the field of medical care, and its possible position in the scheme of health insurance.

If that is your pleasure I shall proceed along those lines, and if there is too much wandering into needless byways, the chairman will feel free to take suitable action.

(5) At the outset, in order to proceed with system, will you allow me to define some of the principal terms to be used:

First the Canadian Pharmaceutical Association is a link connecting together the statutory pharmaceutical bodies of each province. These provincial bodies are each constituted in virtue of a provincial statute or "Pharmacy Act." And every person licensed to carry on the occupation of a pharmacist or "chemist and druggist" at retail must be a member of the statutory body. These bodies regulate pharmacists as to conduct and standards of service, and provide facilities for education and training.

They are perfectly adapted for assuming directional duties under a health insurance plan without any very extensive, or expensive regulating machinery in addition.

(6) This defines the associations, now let us define a pharmacist:

A pharmacist or "chemist and druggist" is the licensed custodian of the poisons, dangerous drugs, medicines, chemicals, and animal and vegetable substances for medicinal, veterinary, household, and technical uses in each community.

While the pharmacist's duties are legion, the conception of "custodian" seems to be a fundamental one. The alternative title of "apothecary" from the Greek "*apo tithimi*" indicates that function as being prominent in the Greek-speaking Mediterranean world, and it appears continually throughout the history of the occupation. In *Romeo and Juliet*, Shakespeare observes its subsistence in pre-medieval Italy. When the apothecary of Mantua is asked for the poison, he replies:

"Such mortal drugs I have;
but Mantua's law
Is death to any he that utters them."

RESPONSIBILITIES

(7) And to-day, as always, the pharmacist has numerous statutory and common-law and professional responsibilities to the people. With the advance of science these legal and professional responsibilities are increasing, and becoming more complex, and more cogent, and the importance, therefore, of the selection of young men and women of sound instincts, and natural aptitude, and the providing of better education and training for the work, increases in importance to the people of the nation. At the present the typical standard for admission—educationally—is an honour matriculation of a selected direction; some three years of training in a pharmacy, and two or three years of college work in pharmacy, chemistry, biology, botany, microbiology, materia medica, pharmacology and many other related studies. The training in all the provinces is similar in standard, but not identical, and great progress in the improvement of the education of pharmacists has occurred throughout the American and European worlds.

EDUCATION AND TRAINING

(8) However, when a man graduates from a college of pharmacy to-day, he still is by no means omniscient in the science—he stands only at the edge of a field whose boundary he will never reach—and one who like myself has experienced many years in the occupation realizes by contact with those who have advanced education and training how much more useful to his people he could be, if he had better education and more training.

Improvement in the education and training of pharmacists, is something of very great importance in the interest of the nation.

LICENSING

(9) Having received his education and training, the pharmacist is licensed, and stands in the midst of a stock of several thousands of medicinal items, gathered together from every part of the world, and his training must embrace experience and instruction in the numberless properties of all these entities. He must be able to compound them, preserve them properly, and test them variously, for he has legal responsibility for their integrity, as we have already indicated.

RELATIONSHIP TO OTHER GROUPS

(10) Now having defined the associations and the pharmacists, and observing that his duty in medical care is to procure, prepare, and dispense the tools of the doctor, nurse, and dentist, in the form of medicines, materials, and appliances, let us see what is the nature of his relationship to other descriptions of people participating in medical care.

Throughout the history of medicine and pharmacy, the two occupations have often been entangled together, and there have been jurisdictional disputes and friction. In England, I am told there is a society of apothecaries who now practise medicine as a result of a decision of the supreme court or privy council at a period shortly after the great fire, that the members of the society were entitled to prescribe as well as dispense.

But in our time these differences tend to minimize and disappear with the advancement of science. To prescribe medicine is no longer claimed as a suitable field of activity for pharmacists, except in the realm of the commonplace, where it amounts to no more than a bare recital of the obvious properties of simple household medicines, to which no one, least of all physicians, will object.

And the field of medicine is now so vast that it engrosses the full attention of a doctor to master and keep abreast of the developments that are indispensable to his proper activity.

The teaching, then, of pharmacy proper in medical schools tends to occupy a very minor place, and a physician's training in pharmacy is not practical. Pharmacy can only be learned by doing it, as well as knowing it.

So that physicians progressively dispense little medicine, except in remote areas and in emergency.

And since it is the future we plan for—in which by the rapid extension of roads, and the strides in easy transportation which we may anticipate after the war—fewer and fewer areas will be remote and pharmacists will be within the reach of almost all of the people.

AVAILABILITY OF PHARMACISTS

(11) Now it is greatly in the interest of the people of the nation that there be an adequate distribution of pharmacists—people in smaller centres are entitled to have the services of a pharmacist as well as those in larger places—and in view of the mounting costs of education for pharmacy, and to make it possible for a pharmacist to maintain himself in these small towns, it becomes a matter of national importance to have the duty of providing medicinals, and all the tools of medicine, restricted as far as the peoples convenience will admit, to pharmacists; to be provided with mills, you must have a reasonable supply of grists.

This proposition, naturally, does not meet with any objection from anyone, as far as I am aware.

COMPOUNDING

(12) Let us now consider the sources of the tools of medicine as they pass through the hands of the pharmacist. The occupation of pharmacy like most other occupations, has been affected by the industrial revolution, and in it the division of labour occurred somewhat later than in the case of other forms of production. No friction to speak of occurred in pharmacy between hand workers, and those who proposed to utilize machinery and to initiate production on a large scale.

So that certain operations which by their nature can be done in manufactories, cheaper or better or both, than in small shops—these are done in large manufactories. On the other hand there are numberless operations in pharmacy which must be done freshly before the use of the product, and the limitless number of combinations make prefabrication impractical in a large number of cases. These things are done in the retail pharmacies. Hand operation in retail pharmacies is rather on the increase now than on the decrease.

So the "crude drugs" flow from their collectors not only into the retail pharmacies, but very largely into the vast chemical and pharmaceutical manufactories to be fabricated.

Now these large establishments, being businesses of considerable size and great enterprise—not only fabricate the medicinals according to the knowledge and standards of the past up to now, but they also take a very great part in the work of perfecting the tools of medicine by means of their experience and especially by means of their great research enterprises.

It is true that universities, endowed foundations, and governments also engage in research for the improvement of medicines, but the pharmaceutical commercial houses are provided with better funds and are spurred on by competition, and it can be said that the part they play in the revolution which now goes on in medicinal types—that part is really a startling one. The example of the production of M. & B. 693 in the laboratories of May and Baker, which gave rise to the use of the sulphanilamides; the prompt follow-up by other houses bringing in sulphathiazole, sulphadiazine, etc., is an eventuality which only large scale enterprises would be at all likely to accomplish so quickly. This item—so fruitful for medicine in the past few years, is only one of numerous others of great significance, that now go on.

MEDICINE OF TO-MORROW

(13) And if I might raise the point at this juncture, it is obvious that the nation cannot secure the advantages of this enormous enterprise without paying something for it.

The medicine we propose to place at the service of the people of Canada is the medicine of to-morrow—it is not merely the medicine of to-day and of yesterday. When one considers the saving to the nation in time lost from labour alone—not to speak of any further advantages—from the use of the sulphanilamides alone—one can see how shortsighted it would be to do anything to curtail the revolutionary progress in medical tools now being made under the auspices of these great enterprises.

To borrow a comparison from the publishing industry—sometimes public medicine schemes have thought to pay only for the cheaper reprints, and never for the original editions. If there are not purchasers for the original editions which cost a lot to bring out, then there will be no "reprints" and progress is halted.

ESTIMATED COSTS

(14) Now since we have seen roughly what goes on in the processes of pharmacy, let us look at the estimated costs.

Because as we have said, the medicine contemplated is that of tomorrow—and a revolution now goes on quite rapidly in the field—we cannot tell what it is that we have to pay for, and therefore, talk about close budgeting is out of the question. It is reasonable to suppose that to a degree any one pot will be assured by the others, if one goes empty there may be money left in the others to rescue it.

The figure of 28 1/2 millions odd may well be as good a guess as any.

Let us run over the few and sketchy figures we have to guide us in this matter.

According to the census of 1931, upon the activities of 1930, the sales of drugs in pharmacies (prescriptions, drugs, compounds, and sundries) were \$51,180,000. From this figure one may estimate the cost of sales at about \$33,267,000 and the inventory—assuming a probable turnover of about two and one-half times a year, would come to \$13,307,000. Since that is thirteen years ago, it is probable that the present inventory of drugs at cost to the pharmacist, is \$16,000,000 or more.

Now prescriptions sold for \$12,004,000 in 1930, exclusive of medicines given out by physicians, drug sundries—syringes, hot water bottles, hypodermic supplies, etc., came to \$5,397,000.

This totals \$17,401,000.

In the intervening thirteen years these figures would be materially increased, and it is not unlikely that the total sales would now exceed \$22,000,000.

Under health insurance it is natural to anticipate that some doctors who now supply medicines to patients—being more fully occupied with the duties of preventive medicine, and with the detail of the more thorough medical care for all the people that is expected, will discontinue that practice, and that with the improvements in transportation which will make remote areas less remote, there will be less need for that—so that a larger volume of medicines should pass through the pharmacies.

More patients will seek consultation with physicians if not withheld by monetary considerations.

A greater variety of sundries and a greater volume of them will be demanded.

All of which is likely to increase the demand upon the scheme for the tools of medicine.

On the other hand, as Dr. Routley indicated in his presentation, the curative services should, in time, be limited by the operations of the preventive features of the scheme.

And from this point of view it is incontestable that the best tools for medicine to work with will be worth more than they cost—be that cost what it may.

For the cost of the medicines and appliances, and materials, the people of Canada will get:—

- (a) The services of the collecting agents who secure and convey the raw materials from every quarter of the globe.
- (b) The services of a chemical, and pharmaceutical manufacturing industry, which is fully up to the minute in every way—is performing the tasks of research, experiment, and production in admirable fashion, and which maintains a system of publicity and information for physician, nurse, dentist, and pharmacist which is beyond value in bringing the new medicines into practical use, as soon as they are well tested pharmaceutically and clinically.

- (c) A distribution service which places the medicines in the pharmacies throughout the nation where they are available.
- (d) The services of 3,800 retail pharmacies operated by about 5,600 qualified pharmacists, and numerous ancillary personnel.
- (e) The services of the teaching and training institutions in the provinces, affiliated with the universities, and largely or wholly paid for out of the funds of the pharmacists and the students themselves. The Ontario College of Pharmacy, which trains nearly half of Canada's pharmacists, has never, I believe, received a grant of any sum whatever from any governing body. The others are probably in somewhat similar case—I do not know precisely.

We propose, in short, to give the people of Canada a real bargain.

FORMULARY

(15) The question of the provision of the lists of suggested medicines—suggested, not as being obligatory in use—an independent physician must obviously be permitted to practise medicine with any medicines he thinks will do the most good to the particular case in hand. As Dr. Archer said to you: "It is not a machine the physician practises upon, but an individual human being, whose needs may be quite various," but the lists of medicines suggested as convenient in general practice—this question need not detain you.

A formulary will probably be easily prepared by a committee, or committees, who will incorporate in it the best suggestions from every quarter so that physicians and patients everywhere may be inconvenienced by it and not hampered by it.

At this point I would call your attention to a circumstance which may surprise you a little. One could be excused for supposing that pharmacists might want to sell as much medicine as they can—business is business—and one could easily suppose they would be highly interested in the amount of money budgeted for medicines to pass through their hands.

But it did not surprise me to find that not a single enquiry came in from any pharmacist about the money to be budgeted. Their primary interest did not lie there at all.

But one thing in which they showed the keenest interest was the initiating of some steps to restrain any tendency to overuse of medicine by the people—particularly at the outset, when the idea of getting something because it costs nothing might influence people to make demands upon their doctors for orders for more medicines than their real need warrants.

The pharmacists showed great interest in a suggestion that medicines be insured in part only in order to make an automatic brake upon over demand for medicine. However, Dr. Heagerty has mentioned in his evidence that this question might be left to the provinces to decide. If any other means can be devised to attain the same end, it will satisfy the pharmacists.

The point is that the pharmacists definitely do NOT want to sell all the medicines they can sell regardless of need. That is a point on which absolute unanimity prevailed in our correspondence and consultations. A few objected to partial insurance for other reasons. All, without exception, were interested in methods of curbing over-supply of medicinals.

Mr. McCANN: Can you give us an idea of the relationship between the amount of money spent in Canada for medicines and drugs that are prescribed and patent medicines which you sell over the counter?

The WITNESS: My memory is useless for figures, but in my bag I have a book and after I have finished I will get that figure for you, if I may. May I now summarize before I answer your question?

Mr. McCANN: I thought it might fit in there.

The WITNESS: I am sorry that I cannot remember figures. It is awkward.

SUMMARY

16. So the suggestions of the pharmacists—while we shall here recapitulate the principal ones—really scarcely need to be stated.

You will all, I have no doubt, be minded to incorporate them in an enabling Act whether we state them here or not.

1. A democratic administration, with pharmacists represented on the administrative commissions.

2. Provision to utilize the present organization of pharmaceutical bodies constituted in virtue of provincial Acts, for the purposes of consultation, cooperation, information, and advice upon details.

3. Arrangements to restrain any tendency to the overuse of medicine, without too many inspectors and administrators.

4. Provision for keeping the people provided with the best types of medication and appliances.

5. Care that nothing be done to restrain progress in perfecting the tools of medical science in the forms of medicines and appliances, and provision to keep the people of Canada supplied tomorrow with the medicines of tomorrow.

6. Arrangements to keep the proper duties of pharmacists—the custody, care and preparation of the peoples medicines restricted to licensed pharmacists—except in remote areas and emergencies—so that the small fraction of the budgeted sum for medicines, which is actually available to pharmacists—after the manufacturer and the expenses have been looked after—so that this small sum shall not be too greatly insufficient to maintain and extend the teaching of pharmacy, and to make it possible for all or nearly all the people of Canada to have the services of a pharmacist available to them.

On pages of 36 and 37 of the draft Act in evidence before you, further provisions for making arrangements with the pharmacists are set forth.

The pharmacists see no reason to disagree with the judgment of the advisory committee in these suggestions, and together with the principles I have just stated, these represent the majority opinion of the pharmacists of Canada upon a workable plan for the supply of medications. It is not necessary to read that section of the draft Act.

PHARMACEUTICAL BENEFIT

30. (1) For the purpose of administering pharmaceutical benefit, the commission shall, in accordance with regulations made hereunder, make arrangements for the supply of proper and sufficient drugs, medicines, materials, and appliances to qualified persons, and the regulations and arrangements aforesaid shall be such as to enable qualified persons to obtain such drugs, medicines, and appliances, if ordered by the practitioner by whom the qualified persons are attended, from any persons with whom arrangements have been made, and shall be such as to secure, subject to such terms and limitations as may be included therein,

(a) that, except to the extent to which medical practitioners and dental practitioners may, in accordance with the arrangements made with them, be required to supply such drugs, medicines, and appliances for

- immediate use or in emergencies or in remote areas, arrangements shall be made only with retail pharmacists (including chemists and druggists) registered in the province;
- (b) that lists of pharmacists with whom arrangements have been made as aforesaid shall be prepared and published;
 - (c) that any pharmacist registered in the province desirous of being included in any such list as aforesaid shall be so included on making application therefor in the prescribed manner;
 - (d) that the person for whose benefit an order for any drug, medicine, material or appliance is given shall have the right to select the pharmacist by whom the order shall be filled;
 - (e) that except as may otherwise be prescribed, a pharmacist shall not supply drugs, medicines, materials, or appliances if the order therefor is written in such manner as to necessitate reference on the part of the pharmacist to a previous order; and
 - (f) that orders for drugs, medicines, materials and appliances supplied shall be priced by a central board, bureau or committee for the whole province in accordance with a tariff agreed upon between the commission and associations representative of pharmacists, and in accordance with regulations made in that behalf.

(2) Regulations may be made hereunder from time to time authorizing a provincial drug formulary for the purpose of this Act.

Will you excuse me a minute while I go out and get my bag to answer the gentleman's question?

The CHAIRMAN: Have you anything to add, Mr. Corbett?

Mr. CORBETT: No.

Mr. CHAIRMAN: Will you get the answer to Dr. McCann's question, please?

Mr. FULFORD: Is it in order to ask a question now?

The CHAIRMAN: Yes.

Mr. FULFORD: I notice that the speaker, Mr. Burgess, mentioned specifically the sulpha drugs. It strikes me that the time has come when there should be some standardization of pharmaceutical names of drugs, especially in the case of the sulpha drugs. I understand that there are some two hundred odd names, that each firm that produces sulpha drugs has its own particular name. Lilly & Co., is one name; Parke Davis is another name; Merck is another name. When a doctor prescribes he prescribes according to the name he knows, which means that the pharmacist has to stock all these different brands. In other words, he is being asked to carry a much larger stock than would be necessary if there was some standardization in the pharmaceutical name and each company that produces an article should be required to have a standard name for it and not their own trade name. Am I right in that?

The WITNESS: Mr. Chairman, that is one of the great headaches of the medical profession and the pharmaceutical profession. I am not wholly informed upon the matter but I believe that legislation is pending to remedy that. Is that correct, Dr. Heagerty?

Dr. HEAGERTY: A pharmacopœial Committee has been appointed to go into subjects of that kind and has under consideration certain of those.

Mr. FULFORD: I am very glad to hear that.

The CHAIRMAN: Will you answer Dr. McCann's question, please?

The WITNESS: In the census of 1931 upon the activities of the year 1930 physicians' prescriptions are recorded as coming to \$12,000,000, and patent medicines and compounds as coming to \$33,779,000.

Dr. HEAGERTY: If I may be permitted, I just question the reliability of those figures. In all probability they have been published by our own depart-

ment, having been received from the Department of National Revenue, and it is utterly impossible to break down those figures. When we made a study of the cost of drugs in 1935 with the assistance of the Bureau of Statistics we found the total cost was \$55,000,000, but included in that we found were cosmetics and chemical substances that could not really be classified as drugs, so that it is just a question whether those figures are correct.

Mr. McCANN: The new figures in the 1941 census ought to be available now.

The WITNESS: Mr. Chairman, if I might add to what Dr. Heagerty has observed in this regard, there is ambiguity in this. It says "patent medicines and compounds." I would not attempt to define it. I do not know what they mean by "compound" there. I certainly agree with Dr. Heagerty that the figures which we have are hardly to be relied upon.

Mr. McCANN: Mr. Chairman, the point that I want to bring before the committee is that the great majority of the public in this country do their own prescribing and they buy patent medicines so that the gross amount of medicine that is being used will not be directed by the medical profession under any health insurance scheme but will continue to be directed by the people themselves and the advertising campaigns of pharmaceutical organizations.

The CHAIRMAN: Does the medical profession object to that growing tendency, Dr. McCann?

Mr. McCANN: Not at all; we just like to have it made known to the public, pink pills and other stuff.

The CHAIRMAN: Are there any further questions?

Mr. McCANN: I would like to ask the speaker if his organization goes on record as being favourable to the principle of health insurance, and whether or not he thinks that there will be advantages which will accrue to his organization and to the general public under a health insurance scheme over and above those which obtain under the present scheme of private industry as carried on by the pharmaceutical profession throughout Canada?

The WITNESS: Mr. Chairman, might I answer Dr. McCann by reading from the first page of the submission, the second paragraph?

I am not provided with any directive from the provincial pharmaceutical associations, nor from the Canadian Pharmaceutical Association to discuss these matters in detail. The small number of representative pharmacists who have seen and read the draft Act before you have not recorded with me their reaction to that experience. Since no significant criticism of its method and tenor has come in from them, one may, I believe, take it for granted that if the legislators in their wisdom deem it wise and necessary to enact along these lines, the pharmacists have not yet seen any reason to question the general form of the plan proposed.

Mr. McCANN: That is not very definite.

The WITNESS: Mr. Chairman, the pharmacists definitely have not expressed any opinion.

Dr. HEAGERTY: I question whether pharmacists should express an opinion in regard to the need for health insurance in Canada. It seems to me that it is the doctors, welfare people, dentists and other groups much more than the pharmacists who are really in a position to express the need.

The WITNESS: Mr. Chairman, it is my personal opinion that the pharmacists should not express an opinion. That is a personal opinion, not necessarily the opinion of any pharmaceutical association.

The CHAIRMAN: Mr. McCann's question was as to whether they had expressed an opinion.

The WITNESS: They have not.

The CHAIRMAN: Any further questions?

Mr. McCANN: There is another question. Would Mr. Burgess like to express an opinion as to whether or not he feels that the position of the pharmaceutical organization of Canada and the position of the public at large would be enhanced and benefited by the introduction of health insurance over and above the scheme which obtains at the present time of private work?

The WITNESS: Mr. Chairman, I do not hold any opinion upon that. Since the details of the plan are not worked out I certainly do not think I would be competent to hold an opinion of that kind. I am anxious to see the welfare of the people of Canada benefited in any possible way, whatever way that may be, and if that should be at the expense of pharmacy and in the interests of the generality of the people of Canada I am in favour of that, speaking personally, and I think most pharmacists are.

The CHAIRMAN: I should like to thank Mr. Burgess and Mr. Corbett for the presentation that has been made. We will adjourn until Tuesday, May 11th at 11 o'clock when industrial health will be discussed.

The committee adjourned at 12.50 p.m., to meet again on Tuesday, May 11th, 1943, at 11 o'clock a.m.

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SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 9

TUESDAY, MAY 11, 1943

WITNESSES:

- Dr. A. L. Walsh, Montreal, President, Canadian Dental Association;
- Dr. D. W. Gullett, Toronto, Secretary, Canadian Dental Association;
- Dr. Armand Fortier, Montreal, Member of Canadian Dental Association;
- Dr. Harry F. Thomson, Toronto, Canadian Dental Hygiene Council;
- Dr. J. G. Cunningham, Toronto, Director, Division of Industrial Hygiene, Department of Health for Ontario;
- Dr. F. C. Pedley, Assistant Professor of Public Health and Preventive Medicine, McGill University, Montreal;
- Dr. C. F. Blackler, Director, Division of Industrial Hygiene, Department of Pensions and National Health, Ottawa.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

TUESDAY, May 11, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Bourget, Breithaupt, Bruce, Casselman (Mrs.) (*Edmonton East*), Cleaver, Coté, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGregor, McIlraith, Maybank, Mayhew, Shaw, Slaght, Veniot, Warren, Wood, and Wright—35.

Dr. A. L. Walsh, Montreal, President, Canadian Dental Association, was called. He introduced the following:—

Dr. D. W. Gullett, Toronto, Secretary, Canadian Dental Association;

Dr. Armand Fortier, Montreal, Canadian Dental Association; and

Dr. Harry F. Thomson, Toronto, Canadian Dental Hygiene Council.

Dr. D. W. Gullett presented a brief on behalf of the Canadian Dental Association, and all the above mentioned doctors were examined by the committee. After receiving from the chairman the thanks of the committee for the valuable evidence submitted, the witnesses retired.

Dr. J. G. Cunningham, Director, Division of Industrial Hygiene, Provincial Department of Health of Ontario, was called. He introduced:—

Dr. F. C. Pedley, Assistant Professor of Public Health and Preventive Medicine, McGill University, Montreal; and

Dr. C. F. Blackler, Director, Division of Industrial Hygiene, Department of Pensions and National Health, Ottawa.

Dr. Cunningham presented a brief on Industrial Health.

The above named doctors were examined by the committee, and after being thanked by the chairman, retired.

The committee adjourned at 1.00 o'clock, p.m., to meet again Friday, May 14, at 11.00 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

MAY 11, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: This morning we shall hear representatives of the Canadian Dental Association. I will ask Dr. Arthur L. Walsh, President of the Canadian Dental Association, to introduce the representatives.

Dr. ARTHUR L. WALSH: Mr. Chairman, ladies and gentlemen, as President of the Canadian Dental Association I may say that we are more than happy to be here to discuss matters relative to the health of the Canadian citizens. It is my privilege to introduce our General Secretary, Dr. Gullett, who will present a brief. Dr. D. W. Gullett, from Toronto. Following Dr. Gullett I shall ask permission of the chair that Dr. Armand Fortier, a member of our Canadian Dental Association executive and President of the College of Dental Surgeons of the province of Quebec, be allowed to speak; and following Dr. Fortier that Dr. Harry F. Thomson, who has twenty years' experience on dental public health and now Field Secretary of the Canadian Dental Hygiene Council be heard. I would ask also the privilege that these three gentlemen be allowed to speak before questions are asked on behalf of the Dental Association.

The CHAIRMAN: Thank you, Dr. Walsh. Dr. Gullett, will you come up here, please?

Dr. D. W. GULLETT, called.

The WITNESS: Mr. Chairman, Hon. Mr. Mackenzie and members of the committee: The representatives of the Canadian Dental Association are pleased to appear before this committee to-day in order to present the view of the dental profession across Canada upon health insurance in so far as it relates to dentistry.

The Canadian Dental Association was organized in 1902 and is an incorporated body by Act of parliament, Dominion of Canada. The constitution states that the objects of the association shall be:

- (a) To cultivate and promote the art and science of dentistry and all its collateral branches, and to maintain the honour and interests of the dental profession;
- (b) To conduct, direct, encourage, support or provide for exhaustive dental and oral research;
- (c) To elevate and sustain the professional character and education of dentists;
- (d) To promote mutual improvement, social intercourse and goodwill among the members of the profession;
- (e) To enlighten and direct public opinion in relation to oral hygiene, dental prophylaxis, oral health and advanced scientific dental service;
- (f) To disseminate knowledge of dentistry and dental discoveries;
- (g) To have cognizance of and safeguard the common interests of the members of the dental profession;
- (h) To publish dental journals, reports and treatises;
- (i) To do all further or other lawful acts and things as are incidental or conducive to the attainment of the above objects.

Every practising dentist in the Dominion of Canada is a member of the Canadian Dental Association. The membership is made up of corporate members and ordinary members. The corporate members are the provincial dental boards or councils in the various provinces whose membership is voluntary. These corporate members provide the finances of the association by annual grants. Each province is divided into districts or areas. The dentists practising in each district elect a member to the respective board. This provides a purely democratic body to represent the dental profession in Canada with a minimum number of organizations. It should be emphasized that the entire membership of the dental profession in every province of the Dominion of Canada is consequently represented by the Canadian Dental Association.

The association for several years has given much study to plans for dental service to a greater number of the population. The various forms of health insurance now existing in the world have been carefully studied. Every effort has been made to evaluate the good and bad features of all the various arrangements.

Approximately one year ago the Department of Pensions and National Health requested the Canadian Dental Association to present a plan for the co-operation of the dental profession in a health insurance arrangement for Canada. A plan was determined at a meeting of the delegates representing every province and later approved in an open meeting of the association. Representatives met the government advisory committee at a later date and presented the plan. Since that time there has been no important change in the original plan.

While we do not desire to be understood as advocating the introduction of a health insurance plan without much further study than has yet been given to the problem, we do wish to record our conviction that it would be undesirable to introduce any public health or health insurance plan without the inclusion of the essentially preventive dental service proposed herein.

We do not think that any plan will do away with dental disease in its entirety. We firmly believe, however, that the arrangement herein suggested will reduce the amount of such disease as far as is humanly possible.

During the childhood period is the most feasible and economical time in the life of the individual when control of dental disease can be put into effect. The ravages of dental caries among the children of the nation is a well known condition among all public health officials, often spoken of as a national disgrace. It is pointed out that surveys, where no school dental services have been in effect, now show a condition of 95 to 98 per cent of the children possessing carious teeth. In those municipalities where such service has been instituted, the incidence of dental caries is reduced a considerable amount, varying from 40 to 50 per cent in many instances. A factor which hitherto has militated against the reduction of dental disease has been the lack of financial resources in many cases. The provision of this financial support would produce a better situation, the result of which should be the establishment of a future Canadian population possessing abundantly more dentally fit oral conditions. The dental profession does not wish to go on record, due to the lack of personnel, as able to care for all the insured herein suggested, but does undertake to carry out the proposed plan to the best of its ability.

The profession, taking into account the available personnel and the wise expenditure of moneys, are long since convinced that the best method of properly attacking the problem of dental disease is through the child. The retaining of a child's mouth in a condition of health is an objective far more obtainable than making any attempt to remedy the condition of the dental cripples among the whole population.

Insured Persons

In the event that health insurance legislation is enacted in Canada, the profession advocates the institution of a compulsory dental health insurance plan for all children up to the attainment of age sixteen. It is now realized that all provinces, if any, will not be able to undertake this whole obligation, so it is recommended that each province be left to decide the age limitation. As will be explained later, this is the initial development period of the plan.

Administration

Great emphasis is laid upon the fact that to be successful the administration of dental matters must be under the direction of members of the dental profession. Any student of the various plans for health insurance which have been instituted in other countries will find that there exists great danger for dentistry in the type of administration adopted, in fact both the type of service and the profession have been all but ruined in some countries by the system of administration.

The adoption of the present proposals will eventually lead to a plan whereby the great majority of the people will receive dental treatment under the arrangement. This will depend to a large extent upon an increase in dental personnel. The dental profession, quite probably, stands in need of greater increase in numbers, if health insurance is adopted, than any other group concerned. In order to cope with the oral health of the nation we are not at all certain but that there will need to be nearly as many dentists eventually as there are physicians at present. The present number are only capable of rendering adequate dental service to about one-quarter of the population. Thoughtful men will pause to consider the type of young man who will be attracted into the dental profession. If the whole project is to work out satisfactorily and be fair to the public it must first be fair to the profession concerned. It can be readily understood if the administration is not fair to those rendering the service the type of individual entering the profession will be lowered. This tendency has been observed in the plans now under operation in other countries and this association considers that the danger should be pointed out to you. Dental health service is essentially a personal service and the adoption of a system, no matter how perfect, means little if the personnel becomes debased thereby.

The present autonomy of the dental profession on this continent is well known. At the same time it should be stated that dentistry in Canada and the United States is recognized as the foremost in the world to-day. These two statements are definitely inter-related. With the adoption of health insurance plans in some countries the dental profession has been so overshadowed by means of administrative authority that the profession has been pushed back half a century in development. The Canadian Dental Association cannot sit back at this critical period and knowingly see such a situation occur in Canada. We are proud of the position dentistry occupies in this country to-day. The present respect the profession obtains was won by men who gave all they had for dentistry. The advance in dental science, the high status of the profession, and the unequalled type of dental service being rendered the public have developed under the present system of practice. If the administrative status of the dental profession is now made retrograde through legislation, our cooperative effort for the future health of this country, we believe, will prove to be a damnation to both the public and the dental profession with the passage of time.

Plain words are better spoken initially than after the dire effect has become evident. In other countries too often the dentist has arrived in a subservient position through the type of administration adopted. Only dentists know dentistry. The profession must be adequately represented if dental health insurance is to be successful.

One of two conditions must obtain, either the dental profession must have adequate representation in any cooperative plan for administrative purposes or

the administration of the part dentistry is to play must have separate administration either in part or in whole. In the interests of those who are to receive the services, the profession must be left free to govern purely dental matters. Consequently, we believe that the dental profession must have adequate representation in the coordinating agency of any cooperative plan and the profession must be left free to govern and administer that section of the cooperative plan which deals with the administration of dental matters and dental personnel.

The members of the dental profession of Canada are anxious to cooperate in a health insurance plan which will extend dental services to more of the population, but we wish to point out that 100 years of dental history on this continent confirms the fact that every time dentistry has attempted integration with medicine the result has been a loss to dentistry, which is easily understood, because medicine has so many problems and the dental problem becomes only one of them. The profession requests adequate representation on proposed committees and councils so that the progress of dentistry may not be stifled.

It has been suggested that the province is to be divided into regions or areas for the administration of health insurance. These areas are to be presided over by a regional council, the head of which, and his assistant, if necessary, to be a member of the medical profession. For the plan to be workable it will be in our opinion necessary to have a dental officer in each of these areas who will be responsible for carrying out the plan for dentistry. The administrative relationship of this dental officer to his professional confreres, the beneficiaries, and the whole plan will be of vital importance to the success of dental service under health insurance.

The Canadian Dental Association favours:

(1) That there shall be established provincial coordinating commissions which will be representative of the groups concerned. It is pointed out that one inherent danger of commissions, especially small commissions, is that they may become dictatorial in action. There is a great deal to be said, in our opinion, for larger commissions with equal representation of the groups involved in the whole plan.

(2) That the lieutenant-governors in council in co-operation with the provincial dental boards shall establish a dental benefit committee, the said committee to be responsible to the commission for the administration of all dental services and all that relates to the practice of dentistry under the Health Insurance Act.

(3) That a dominion council on health insurance, representing all groups on an equal basis, be established under the federal Department of Pensions and National Health.

(4) That all executive officers that are found necessary under the operation of the Act as it pertains to dentistry are to be members of the dental profession in good standing.

Benefits Available

1. A dental examination shall be given once every six months.
2. Prophylactic treatment shall be given once every six months, when necessary.
3. Plastic filling material shall be used in restorative work.
4. Provision shall be made for the use of special materials and appliances for the treatment of accident cases.
5. Extractions and necessary dental surgery to be performed when necessary.
6. Anaesthetics shall be used where necessary.
7. Arrangements shall be made available whereby the patient may be referred for special services.

8. Radiograms to be used where considered necessary.
9. Provision shall be made for the use of such other materials as may be required in carrying out the usual procedures in the practice of dentistry for children.

Basis of Payment

For all children up to the attainment of the age of sixteen years, who come under the provisions of the Health Insurance Act, there shall be provided payment in full from the insurance fund to the dentist, based upon a schedule of fees as recommended by the respective provincial dental board.

Explanation

The plan shall be advanced from the attainment of the age of sixteen years upwards to seventeen years, etc., as is deemed advisable from time to time according to the availability of personnel, financial support and general considerations. It will be realized that the added years will be, in the main, composed of those who have been under the provisions for dental services. By the gradual increase of the age at no time will the plan be faced with the problem of the accumulated dental needs.

The backlog of dental needs among the whole population has always been the great deterring factor against the institution of any large scale plan for dental services.

The Dominion of Canada would be in the position of being the first country to institute a definite and thorough plan of control in the field of public health as far as dentistry is concerned. In the event of a physical examination of manpower at some future time after the plan had been in operation the result would be far different from that experienced at the beginning of the present war, when it was found that approximately 23 per cent of the available manpower was discovered to be unfit for enlistment due to dental defects.

This plan is supported by the Canadian Dental Association for the reason that it is believed to be the only one economically sound and within the power of the dental profession to supply the necessary service with the available personnel at the present time. Further, the dental profession in Canada has no desire to enter into an agreement in which the requirements for dental services are such that the profession has no means of supplying, even if the financial outlay required were underwritten. It is the considered opinion of this body that any attempt to render impossible services would result in not only the failure of the entire arrangement, but would bring great discredit upon the profession of dentistry.

To meet the demands of the future expansion of the health insurance plan, as it affects dentistry, the following proposals are submitted:

1. For dental research, in an effort to reduce the incidence of dental disease, an annual grant to be made.

The dental profession keenly feel that it is most necessary to have an associated plan for research accompany dental health insurance. Two main purposes can be readily observed: (a) the cause of dental disease has not been satisfactorily determined and the plan offers an opportunity not known previously for regulated study in a determined effort to reduce the incidence of this most widely spread of all diseases of mankind, (b) such a research laboratory would be in a position to constantly observe the working of the scheme with the objective of improving the individual dental operations. Research should be carried out in connection with the dental schools where the resources of other faculties of the universities are available and now established.

2. For dental health education of the public in general and the dental profession an adequate annual grant to be made. The profession is convinced that education on dental public health is essential for the success

of any such plan, as has been proven by past experience, and fully believe that such effort will materially reduce the cost of treatment.

From time to time the dental profession in Canada has been given credit by public health officials for the work done in the field of dental public health. Professional organizations have used their own funds in order to carry on this educational activity. In some measure the effort has been successful. The average individual has at least heard that he should go to the dentist every six months. At all times the profession has been handicapped for funds to carry out a programme of dental public health education.

Members of the profession know that in order to make the proposed plan for dentistry successful dental health education will need to be intensified. Any moneys expended for this purpose will give multiplied returns in reduced treatment costs.

Calculation of costs is apt to become the main consideration in making arrangements for health service plans whereas the objective is to improve the health of the nation. Provision of perfect arrangements to render services might quite possibly fall far short of the intended result unless accompanied by an intensive plan for dental public health education.

3. For dental education in view of the fact that the personnel will need to be drastically increased in order to cope with the future increase in numbers of insured individuals, a sufficient amount to aid the dental schools of Canada.

4. That at the time of increasing the age limit under the plan, adjustment will be made in the Health Insurance Act in so far as it affects dentistry both in the benefits to be provided and the basis of payment. These and any other future adjustments to be made with the cooperation of the representatives of the dental profession in Canada.

The Canadian Dental Association believes that the principles of private initiative and freedom of choice are vital to the success of any health insurance plan for Canada. The patient must be free to choose his dentist and the dentist free to choose his patient. The independence of the profession must be retained so that the progression of professional development may not be hampered. Where there is no freedom of inquiry and freedom of expression there is no intellectual growth. Prevention rather than the curative must hold a dominant position if such a plan is to succeed. The opinion of the association is that the practice of dentistry should be carried on in the private office of the dentist except under circumstances not favourable to private practice and the determination of the need for dental services shall be the prerogative of the dental profession. The truth of these principles has been established among the members of the dental profession both through the study of plans existing in other countries and by experience in actual dental practice.

The introduction of a health insurance plan should solve the problem of post-war rehabilitation for the dental profession. The dentist now serving in the military forces would have an assured place to occupy in civilian practice. Indications are such that the number of dental students will be greatly increased with the cessation of hostilities, as occurred after the last war. These factors should facilitate the initiation of the whole arrangement for dental services to the increased numbers of the population who are to benefit under the plan.

It is but the summing up of what has been said in this presentation to say that the dental profession in Canada looks with favour upon the principles underlying dental health insurance. The Canadian Dental Association, however, expresses the opinion that the achievement of the desired results will depend upon satisfactory administrative machinery. The practice of dentistry has never been successful except when under the administration of members of the profession, as has been pointed out, and there is no reason to believe from an examination

of other plans for health insurance now operating that the public would be the recipients of the intended dental care if the administration is under those outside the dental profession.

Emphasis is placed upon the danger of placing the administration of matters relating to dentistry in the hands of those who know little or nothing about its affairs. Disregarding the interests of the profession entirely the result would in our considered opinion be unfair to the insured. The dental profession of Canada expresses a strong desire to cooperate in a plan for health insurance, if adopted, but does not wish to become a part of an arrangement for administration which has been proven unsatisfactory through past experience.

The CHAIRMAN: Thank you, Dr. Gullett. Now, Dr. Walsh, I understand that you prefer that questions be deferred until after Dr. Fortier and Dr. Thomson address the committee.

Dr. WALSH: That is what I would like if that meets with your approval. I shall ask Dr. Armand Fortier, a member of the executive of the Canadian Dental Association, and chairman of the board of the College of Dental Surgeons of the province of Quebec, to address the committee.

Dr. ARMAND FORTIER, called.

Dr. FORTIER: Mr. Chairman, ladies and gentlemen, I shall open my remarks in French. (Translation follows.)

It is both as member of the executive of the Canadian Dental Association and as president of the College of Surgeon-Dentists of the province of Quebec, that I have accepted to appear before this committee. Dr. Gullett, secretary of our association, has exposed the views of the dental profession on the plan now under study. Those views I adopt as mine, gentlemen. The fact of limiting dental benefits to the school-age children strongly militates in favour of the eventual success of such a plan.

Now, I shall continue my remarks in English. The fact of limiting the dental benefits to school age children greatly militates in favour of the eventual success of this plan. It has been a recognized fact in other countries, notably in England, that any attempt to provide total dental services for the entire family would eventually wreck such a health scheme. Furthermore, as we know, that restorative treatment will, of necessity, be accompanied by dental health education we can logically hope that such an age group, after having received dental benefits for a period of ten years will be in a position to take care of the health of their teeth and will not allow themselves to become dental cripples later in life. The secretary of our association has attracted your attention to the matter of administration. Allow me, gentlemen, to stress this point. You will agree with me that dentistry has accomplished tremendous progress in the 100 years since it established its identity as a specialty of the healing arts. It is logical to conclude that this progress will endure and increase under a continued state of autonomy. If, on the other hand, this autonomy is denied under a plan in which its powers will be only advisory or even its administrative powers limited, it is our fear that the profession will as a consequence lose the initiative of which freedom was the incentive, and merely become a cog in a machine.

Can you imagine a profession which has made such steps within the field of science within its relatively short span of life relinquishing its prerogatives and yet continuing to develop and advance? We are satisfied with the federal aspect of the administrative set-up. Concerning the provincial administration if administration of the professions in the provinces is to be through the professions, then you will have co-operation. We, however, agree that the administration of each profession should be co-ordinated and subject to ratification or veto by a co-ordinating central body or commission. Mind you, gentlemen, the slight changes which would be necessitated in the draft to meet our suggestions would in no way affect the interests of freedom of any other group. On the

contrary, we maintain that the beneficiary would really gain by such changes. We would be ready to subscribe wholeheartedly to a plan which would be administered under the broad lines as already outlined.

In conclusion, gentlemen, I have a suggestion to make which, although it does not come within the framework of the health insurance plan, or is outside of your powers to grant, I nevertheless submit, in the hope that it will be forwarded to the proper authorities and receive due consideration.

Considering the enormous problem of dental health which the study of this Act reveals it to be, and in view of the complexity of the questions which will come up for solution in this field, I humbly submit that the government should consider the advisability of appointing a deputy minister of dental health under the Minister of Pensions and National Health. This step may seem premature, but we feel that if dental health presents such a problem to us all at this time it is partly due to the fact that it has been neglected in the past. This decision would relieve the ministry of an added responsibility, and would be in line with the conduct adopted by the government towards other important departments. Foreseeing the problems of all sorts which will arise out of the application of such a plan as is now submitted, we cannot help but feel that such a nomination would prove its usefulness both to the department and to the whole population of Canada. I thank you, gentlemen.

Dr. WALSH: Now, I would like to introduce Dr. Harry Thomson, Field Secretary of the Canadian Hygiene Council, with twenty years' experience in public health.

Dr. HARRY THOMSON, called.

Dr. THOMSON: Mr. Chairman, Hon. Mr. Mackenzie, members of the committee, ladies and gentlemen, I have been asked by Dr. Walsh to talk a few minutes about public dental health education. Dr. Gullett has presented a brief covering the entire field of this dental health bill. In that brief he has included a clause on dental health education. I think he enlarged upon that clause and pointed out to you that those of us who are concerned with this public dental health insurance bill are greatly impressed with the fact that dental health education should not only go in as a part of any dental health scheme but should probably be the most important part of any dental health scheme. Those of us who have had experience with dental health and dental disease—those of us sitting in this room this morning—know that had we known ten or twenty or forty or fifty years ago some of the things that are known as common knowledge to-day we would have been in a different position as regards health, and our mouths particularly would be in a healthier state.

Dental health differs from almost any other disease, for it depends almost entirely upon the patient's action and cooperation. The promotion of dental health by treatment alone would be financially unmanageable and scientifically unsound. The patient himself has a tremendous responsibility in maintaining his mouth health and in preventing a recurrence of disease conditions which we have tried to correct, and we must, through education, convince him of just that.

To carry on a scheme of public dental health without public health education in my opinion would be as ridiculous as treating a boy for poison ivy and failing to tell him how he might avoid exposure to poison ivy or failing to tell him what poison ivy looks like. Failure to carry on dental health education would be as ridiculous as failure to tell people that they can be immunized to diphtheria. It would be as ridiculous as to fail to educate people to purify their milk supply or their water supply so as to eliminate typhoid fever.

You will probably ask, how far can such education prevent dental decay? My answer is it can largely prevent it. It is not only as to its value as a preventive that I am presenting my plea for dental health education, but for its value on economic grounds for the financial saving that would be brought about through a programme of education.

To treat the patient only, to restore lost tooth structure, to take care of diseased mouth conditions, is not sufficient; the patient himself must take the responsibility for maintaining that condition. Therefore, we must educate not only the child but we must also educate the parent as well. The machinery for carrying out this educational plan must involve literature suitable for all ages; it must involve personal addresses and personal contact with the individuals concerned; it must involve addresses to women's organizations, women's clubs and so forth all down the line which modern dental health education has set up and which has proved so very effective. The financial saving brought about by such a scheme would mean that the patient would go to the dentist earlier. If dental services were free to everybody to-morrow, if every dentist in Ottawa opened his office and said there is no charge for dental services, I wonder how many boys and girls sixteen years and under would crowd into those offices? I do not think you would have to have a policeman at the door to keep them in line. The fact is that in order to get children of 13 or 14 or 16 years of age or 7 or 8 or 9 years of age to the dentist it requires the entreaties of fathers and mothers and the nurses and school teachers, the doctors and the dentists and several policemen sometimes. That is due to the tremendous misunderstanding and lack of appreciation of dental services, and because of the lack of knowledge concerning the change that is taking place in dental treatment in the last ten years. I have not had any of it done myself, but I have talked about it a lot, and the change has been tremendous. The old fear of the dentist has been almost entirely eliminated, and we want to tell the boy and girl that story, we want to reach them while still in school. It is not going to do any good to tell the boy that if he does not have his teeth fixed he is going to have heart disease or rheumatism in twenty-five years, but it will do that boy good to tell him that if he has a diseased mouth or diseased teeth he will never become a champion hockey player and will never have the opportunity of playing for Connie Smythe or one of the other well-known famous hockey moguls. And that boy should know that Connie Smythe would as soon have a man with a sprained ankle on his hockey team as he would have one with diseased teeth, because he knows that the poison from diseased teeth is carried through the body lowering his efficiency. This type of educational health work is important and has proved effective. First of all we must tell the boy and girl that they are responsible themselves for their mouth health and sound teeth, and more particularly we must tell the parents. We know there are certain factors that lead to prevention, and we are stressing those factors. There is a tremendous amount of research work going on to-day throughout the world by scientists, medical men and dentists, trying to find the specific cause of dental caries, but we have not found it. We have found certain factors, as you know. The first thing we must do is to build sound teeth through a proper diet. We must carry in the human body the elements required to build sound teeth. We know this is an educational problem and not purely a dental problem. It is an educational problem because the teeth are formed previous to birth. The crowns of temporary teeth, or baby teeth, begin to form at the fifth month of pre-natal life; the crowns of our second or permanent teeth begin to form at the eighth month of pre-natal life. Therefore, what is the good of talking to a boy when he sits down in a dental chair, with four cavities, and say to him, "If you do not do this and that you are going to be in a worse state later on", and so on? What we have to do is go after the father and mother with that educational programme.

To get down to the practical end of it, how would it lessen the cost? It will lessen the cost this way: in the first place education cuts down slightly the incidence of dental decay. We had hoped it would cut it down a great deal, but it has not; however it does this: it induces the father and mother to take the child to the dentist at the very first appearance of dental decay. Now, you may say under a compulsory scheme he must go to the dentist. But, he does not have

to, but when he does go the small cavities can be filled at very little cost. Scientific research covering several million students carried out by the United States public health services has proven cavities occur about one a year. If the young child is taken to the dentist every six months from the time he is six until he is fifteen, the dentist will have taken care of nine small cavities at a minimum cost, whereas if we brought that boy in at thirteen, fourteen, fifteen or sixteen, we have to correct defects at a maximum cost. So I think it is quite possible, sir, to leave with you my enthusiasm for the subject of dental health education covering a period of twenty years. I am trying to impress upon you the fact that any scheme which involves dental health education will result in a financial saving which would in fact be tremendous.

I think that any organized dental health educational effort, Mr. Chairman, should be a dominion-wide one. I think you might well study the work of the voluntary organizations, and if you find some of these voluntary organizations are worthy of carrying on this work then finances must be strengthened to take care of them. If we depend upon the individual provinces each carrying on its particular plan of health education the work will be uncoordinated and less satisfactory. So in any scheme of public dental health let us very fully consider not dental health alone, but a scheme involving treatment and correction, and education that will, in time, improve the general health of our citizens.

The CHAIRMAN: Thank you, Dr. Thomson.

Hon. Mr. MACKENZIE: I have three questions I should like to ask. The first one is in regard to this question of dental public health education which has been very fully answered by Dr. Thomson. Dr. Gullett, in your evidence you said that 23 per cent were rejected from the forces because of dental defects. Have you any figures as to how many of these were readmitted as the result of treatment afterwards?

Dr. GULLETT: No.

Hon. Mr. MACKENZIE: There would be a large number, would there not?

Dr. GULLETT: Yes, when the corps undertook to do dental work, that was at the beginning of the war.

Hon. Mr. MACKENZIE: I imagine a lot have been admitted since then.

Dr. GULLETT: Yes.

Hon. Mr. MACKENZIE: Eventually a large number were admitted.

Dr. GULLETT: Yes, through the efforts of the corps.

The CHAIRMAN: Have you any special accelerated courses in dental colleges in Canada the same as the medical students are getting, any special inducement for their training?

Dr. WALSH: All of the dental schools in Canada have accelerated courses, reducing four years to three, keeping the curriculum continuous throughout the whole year.

The CHAIRMAN: Are there any special inducements being given to the candidates for their training?

Dr. WALSH: Definitely. In the latter half of their course they are accepted if physically fit into the dental corps and receive their \$2.30, or whatever it is, while they are studying, the same as the medical men.

The CHAIRMAN: Dr. Gullett, with reference to the 23 per cent defects, have you any figures with regard to the defectives at the beginning of the last war?

Dr. GULLETT: No, we have not, I am sorry.

The CHAIRMAN: Would you venture the opinion as to whether the defects have increased?

Dr. GULLETT: I do not think the charting system was as complete as it is in this war; the figures would not be of any value.

The CHAIRMAN: We are now ready for questions.

Mr. FULFORD: Regarding the 23 per cent that you referred to, Dr. Gullett, in your statement, I agree with you and I have always believed that the Canadian and American dentists were the finest in the world. Have you any figures regarding other armies, the British army, the Australian army, and so forth; is the rejection greater than 23 per cent?

Dr. GULLETT: We have definite figures only for the American corps, and what they found was substantially the same as ours.

Mr. McCANN: I was going to inquire, in view of the fact that there is an apparent shortage of dentists, both in regard to civilians and the armed forces, has the dental profession anything comparable to the Procurement and Assignment Board with reference to the placing of men throughout the country or supplying the need of the armed forces

Dr. WALSH: I would ask Dr. Gullett to answer that.

Dr. GULLETT: We have just completed, Mr. Chairman, a survey across Canada on the procurements and assignments, and we have now definite information with regard to the matter which has been raised, but I must say we have no authority to move anybody at the present time, nor have we authority to tell them to stay where they are.

Mr. McCANN: Are you supplying the need in the armed forces and what would you say is the shortage with reference to the requirements that you have been asked to fill?

Dr. GULLETT: The armed forces at the present time are short about approximately 600 men; that is, to raise their establishment to one dentist for every 500 men.

Hon. Mr. MACKENZIE: Can you tell us how many are taking training at the present time in Canada?

Dr. GULLETT: How many students?

Hon. Mr. MACKENZIE: Yes.

Dr. GULLETT: Approximately in the neighbourhood of—we shall have about 200 graduates this year, and next year will will have 159. I can get you that figure.

Hon. Mr. MACKENZIE: How long is the course?

Dr. GULLETT: The course is a four-year course.

The CHAIRMAN: Reduced to three?

Dr. GULLETT: Two pre-dental years preceding that, you see.

Mr. MACINNIS: Mr. Chairman, I was going to ask Dr. Gullett if there was a shortage of dentists prior to the war and if there was, what was the reason for the shortage.

Dr. GULLETT: There was not a shortage of dentists under the present idea, as we all know it, our economic condition, but with a real appreciation of dental services and how many men take up the profession, and with the removal of these restrictions, why, we meet a different situation entirely.

Mr. MACINNIS: I was going to ask Dr. Thomson a question with regard to dental education. I was wondering about the results achieved by dental education and if they had reached their maximum or were those results limited by (a) the fact we do not make use of the education or knowledge that we have; and (b) because of the inability of certain people to make use of it because of their financial situation.

Dr. THOMSON: Dental education has not reached its maximum; it has been in operation seriously only for the last ten years. During those years we have been up against this situation, the services we recommended could not be provided; the education has shown an appreciable change in the incidence

of tooth decay in high school boys and girls. We have found it necessary to revise the figures of the incidence of the decay there and we feel that is due to educational work carried on with the parents of high school boys and girls.

Hon. Mr. MACKENZIE: Is the main thing in dental education freedom from fear?

Mr. LOCKHART: To what extent have women entered the dental profession up to the present time?

Dr. GULLETT: Oh, there have been very few women enter the dental profession, comparatively speaking. At the present time there are 252 students in the University of Toronto Faculty of Dentistry. There would be 6 or 8. A question was asked a moment ago in regard to the number of dental students at the present time training in Canada. The number is 506. We have five dental schools in Canada.

Mrs. CASSELMAN: Is any attempt being made, Mr. Chairman, to get more to enter the profession? That is, are those who would like to enter the profession given any deferment in military service?

Dr. WALSH: Yes; a student on being accepted into a dental school is given deferment for the time that he is studying dentistry.

Mrs. CASSELMAN: What about boys who have not yet entered but who would make dentists? Because this thing is going to come up for a number of years after the war.

Dr. WALSH: Well, we have just completed a survey in conjunction with the Medical Procurement and Assignment Board. We have no power. I feel that if such a student came to my dental school at McGill and said he would like to study dentistry but he was only in his first year of Arts and he had received a call from the Selective Service, I think that the Selective Service would accept the recommendation of the dental advisory committee for that district and defer him provided his intentions were serious to study dentistry.

Mr. McCANN: Does not it go further; is not the deferment granted on the condition that he join the service in his profession afterwards?

Dr. WALSH: Yes.

The CHAIRMAN: You curtail in special cases the pre-dental academic requirements?

Dr. WALSH: We are not in a position to curtail the requirements as much as some of us would like to, because there are laid down requirements by the provincial boards. Our provincial board in Quebec insists that the student complete two full years of arts and sciences. We are not in the position, as much as I personally would like, to see that our students take one year of arts and sciences and continue on throughout the summer and to take three science subjects and then be allowed to come in. At the present time we have not curtailed.

Mr. FAUTEUX: Mr. Chairman, as the only dentist in the House of Commons who does not practise any more, I think it is my duty to say a few words to this committee. I wish to congratulate my confreres for the memorandum that they have given this morning. I am sure that every member of this committee knows that teeth are very important. You probably have all heard the motto, "Be true to your teeth or they will be false teeth." We have talked, Mr. Chairman, this morning about personnel. If we are going to have the necessary dentists for the plan we have in mind, or even for the army, I should like to submit a suggestion: would it not be a good thing to have dental nurses? I understand that it has been said that what is important as far as dental hygiene is concerned is to look after the children. When a child reaches the age of sixteen years he is really too old to make any correction. So what is

very important is prophylaxis, what they used to call teeth cleaning. I wonder if we have the necessary number of dentists throughout Canada to look after that important matter, which is very important. I should like to submit to the members of the profession who are here this morning that suggestion for them to study. When the time arrives to do something as far as the dentists are concerned, under the health insurance plan, if we do not have the personnel it will be just too bad for the profession and the public in general.

Dr. FORTIER: I thank Dr. Fauteux for his kind suggestion and I might say in answer that the licensing of permanent dental hygienists certainly has its good points. Moreover, I think some provincial boards—I know the Quebec provincial board is now studying the matter, and we think it would be a very great help in the matter of oral health education in prophylaxis. We know dental hygienists, that is American dental hygienists, because there are no such bodies in Canada, should be preferably feminine, because they feel that in approaching and in preaching the matter of health and education the woman knows better necessarily how to approach the child and interest the young mind in that respect. We have considered and we are studying the eventuality of licensed permanent dental hygienists in the province of Quebec, and I am sure that the idea will gain ground as the study of this health plan is gone over. It would be a great help to the dentists in general and to the population as well if that were brought about, because they would fill a very real existing need.

Mr. WOOD: Mr. Chairman, I was interested in the brief presented by Dr. Gullett, particularly where he suggested that under a national health scheme certain corrections should be made prior to the age of sixteen, and he recommended teeth strengthening in Canada which, I understood, should be taken care of before that age.

Mr. LOCKHART: May I follow that point up? Why are more women not admitted into the dental colleges? I should like to have that question answered.

Dr. WALSH: With regard to the admission of students, the door is wide open; it is purely a matter of academic standing. Any young lady or boy can be accepted into a dental school providing he has the academic standing. We go out of the way to encourage their interest; we send our calendars out to the various high schools and colleges around the country and urge that the students themselves be made acquainted with them. We urge that it be brought to the mind of the student that dentistry needs more of the young men to give that service.

Mr. LOCKHART: Young women too?

Dr. WALSH: We do not stress young women.

Mr. LOCKHART: That is the thing.

Dr. WALSH: Dentistry is quite willing to consider women students; we have one in our school right now.

Mr. HOWDEN: What are the qualifications?

Dr. WALSH: The qualifications are the same throughout the United States and Canada, two years arts and sciences to enter the dental school and then four years in peace time. Right now our dental schools are providing that course in three years, three calendar years.

Dr. GULLETT: In regard to the orthodontia problem, we realize that this is one of the vital things in the whole set-up in as far as the condition of the mouth of children is concerned. Up to the present time it has been purely a luxury service because it is very time-consuming on the part of the operator and it is a special service. We have up to the present time a very interesting experiment which is being tried out and has gone far enough along now to show what can

be done in the way of preventive orthodological treatment by instituting the treatment in really young children. That work is being carried on by the city of Toronto at the present time, and it is interesting, and in a scheme of this kind it has great possibilities.

Mr. HOWDEN: What facilities are on hand at the present time for dental education?

Dr. THOMSON: At the present time the organized dental associations of each province have what we call a public dental health committee. They finance their own organization for the carrying on of dental health activities in their own provinces, working under the aegis of the provincial department of health. The Canadian Dental Hygiene Council, a lay public health body which I represent, works under the aegis of the Department of Pensions and National Health. I said aegis; it is sometimes financial support and sometimes aegis. Our function is to co-ordinate the various dental health activities and to extend them. In other words, the Canadian Dental Hygiene Council provides the full-time committee to do the necessary carrying on dental health educational work which is a great help to the provinces when dentists are busy; they are asked to go in and loan their full-time man to carry on the work.

Mr. HOWDEN: What means is taken to contact fathers and mothers so as to get this educational program across?

Dr. THOMSON: There is a very complete organization of all social and welfare bodies in the dominion. They have all co-operated to provided opportunities for personal contact. The women's organizations and the service clubs of Canada have cooperated. That is followed up by literature which is specially prepared to be distributed throughout the dominion for age groups. We had a library but it is being used up. There are moving pictures and films—splendid educational moving pictures and films and there are posters, and these are supplemented by personal service when that is available.

Mrs. CASSELMAN: Mr. Chairman, has the dental profession considered the matter of the use of tobacco as a part of health education; has it considered that the use of tobacco is detrimental to oral health?

Dr. THOMSON: I think, Mr. Chairman, that is something that Dr. Walsh should answer. In spite of anything that may be said I am going to continue to smoke. However, I think Dr. Walsh can answer that question better than I can. I know there has been research work carried on. Unfortunately, it was not carried on scientifically, but it was carried on by a man who was more or less making a joke of it, and he did prove—

Mrs. CASSELMAN: You said proved?

Dr. THOMSON: It did prove that the presence of bacteria in the mouth is slightly lowered by pipe smoking, and also lowered by cigarette smoking, but the lowering of the bacteria lasts only about fifteen minutes. In the habitual smoker there is very little variation, and there is considerable irritation of the tissues.

Mrs. CASSELMAN: What about the scientific examination of the facts?

Dr. THOMSON: I told you that it was more or less started as a joke, but it did show a lowering of the bacterial count for fifteen minutes after the smoker had finished.

The CHAIRMAN: I suppose no one can ever make up for the lost years.

Mr. SHAW: As a result of the presentation of the brief to-day I believe I have rightfully concluded that if a health insurance scheme were instituted that the available dentists would not be able to provide more than approximately 25 per cent of the required treatment, provided that those treatments were taken advantage of; and while the figure was not exactly the same, the same condition prevailed with regard to the medical profession. Now, would not an essential feature of the health insurance scheme be the encouragement, not only by send-

ing out calendars but through financial assistance, of capable students who are desirous of going into the colleges to study dentistry or medicine. That is a most essential phase of any health insurance scheme, and I should like to ask the minister if he will either agree or disagree with that expression of opinion?

Hon. Mr. MACKENZIE: I think there might be some practical difficulty in carrying it out, but it seems a good idea.

Mr. McCANN: Is there any supplementary financial aid given now to students who are taking a dental course, and if so, what is the amount and where does it come from? The other question has to do with something mentioned by the last speaker—

The CHAIRMAN: Perhaps, doctor, you would allow Dr. Walsh to answer your first question first.

Dr. WALSH: There are two sources of assistance for dental students—three sources—one is through the Army, the other is through the provincial grants. These grants are given to students in the first and second years, and in the third and fourth years they are in the army usually, so they really have assistance all the way through their course. We are fortunate in having the Kellogg Foundation grant which we can use, and we are using that as loans at 2 per cent, and we have reason to believe that we can get more money. I think the question of student enrolment is pretty much a matter of supply and demand. If we can show them that in peace time Canada is going to need their services and that there is a demand for their services they will come forward and enrol in our dental schools. It is a question of being able to show them the need.

Mr. McCANN: The second question has to do with this fact: if health insurance becomes operative within the next two or three years will the dental profession be in a position to carry on the increased duties and, of course, that question, perhaps, is easily answered in the negative. The question really is, what steps do the profession contemplate taking to put themselves in a position to meet that need, and what suggestions have they to make to the federal government in order that the profession may be in a position within the next three to five years to meet the demand? If they are not going to be in a position to meet the demand, would they consider that it might be advisable to delay the dental features of the health bill until such time as their personnel is sufficient to give service which will be worth while?

Dr. WALSH: I believe that when this national health insurance plan comes into effect we will have to have increased housing facilities for the teaching of dental students, and for that reason we will have to have financial assistance from some source. I know that at McGill university we can only accommodate twenty in one class—that is the maximum—those are all the facilities we have. Now, somebody has got to help us in providing increased facilities. Brigadier Lott is here, and he has recommended that possibly we shall have to ask the University of Manitoba to start a dental training centre or a dental faculty. I think that given time and some assistance we can measure up to our obligations.

Mr. FULFORD: Mr. Chairman, Dr. Thomson dealt very thoroughly with the prenatal care of teeth but he did not mention the pre-school care of teeth. Now, various organizations such as the Victorian Order of Nurses have baby clinics, and would it not be possible to have clinics for the pre-school child—those below the age of six years? I have always heard that caries in the first teeth can be and often are transmitted to the second teeth, and that it is as important to look after a young child's teeth as it is to look after the teeth of an older child who has had the growth of his second teeth.

Dr. THOMSON: Maybe I could commence at the end of your question. The decay of the temporary teeth does not mean that the permanent teeth will

decay. Dental caries progress independent of whether the first teeth were sound or not.

Mr. FULFORD: That was an old theory, was it not?

Dr. THOMSON: It may have been. There has been a well-organized effort made to take care of the pre-school aged child. Clinics have been formed in all of the larger cities where school clinics are established. In the city of Toronto, every Friday afternoon is devoted entirely to pre-school aged children. At least, it is supposed to be devoted to them, but unfortunately, it is difficult to get a sufficient number of mothers of pre-school aged children to bring their children to take up the full time so that other work is done at that time as well. The Canadian Dental Hygiene Council has been endeavouring to have pre-school aged children treated in all of those clinics carried on by the various provincial governments, and we have succeeded in British Columbia in having a clause written into their regulations, that one child in six treated, must be pre-school age, so as to induce the dentists to persuade the parents to bring their pre-school aged children. It is very important to know that the temporary teeth are equally important with the permanent teeth because they affect the child's appearance and they affect his mastication; diseased baby teeth are as serious to the individual as diseased second teeth.

Mr. SHAW: I readily appreciate the fact that there is a certain amount of assistance given under certain conditions to dental students, but those of us who have taught school have faced the desperate condition where a particularly brilliant child reaches the twelfth grade and completes it and then goes onto the street or takes a job as a labourer, let us say, when such a student might be a wonderful acquisition to the dental profession or to the medical profession. I am concerned about that type of assistance, and not about the type of assistance granted to a student who has probably proven through two years' attendance in a university that he is capable of continuing his studies. I should like to see consideration given to enable high school graduates to undertake studies of this nature when, without assistance, it would be utterly impossible for them to do so.

The CHAIRMAN: That involves consideration of the whole educational policy which we can discuss later.

Mr. SHAW: I want to make my point clear.

Dr. WALSH: The chairman of the committee, Dr. Macmillan, probably could answer that question better than I can. There is no reason why a brilliant high school boy should not take up some vocation in which he has an opportunity to advance intellectually or academically. Every university in Canada has sufficient funds to encourage such a boy.

Mr. SHAW: Nevertheless, we teachers see scores of them leaving high school, and they are never given one iota of consideration by any university or group of people, or offered bursaries or scholarships.

Dr. WALSH: It seems to me that if the high school teachers would co-operate and would introduce themselves to the deans of arts and sciences at the universities and say to them: Here are our boys, I think there would be plenty of support.

Mr. ADAMSON: Mr. Chairman, I heard Dr. Gullett speaking about orthodontia, and he referred to it as a luxury. Now, I happen to have cases quite recently where orthodontia was brought in and I was informed of children of 8, 9 and 10 years having to have bands put on their teeth, and I was interested to find out that if those bands had not been put on their teeth it would have serious after effects and that dental disease might occur. I was informed by quite a number of dentists that you would get dental decay if orthodontia was not practised. Now, orthodontia is an extremely expensive operation, costing on the average I imagine, from \$500 to \$1,000. If we are going to have dental health for children what steps are going to be taken to overcome the orthodontia problem?

Dr. GULLETT: I think the answer is early treatment among young children. As I said a moment ago, that is being tested at the present time and they are getting very satisfactory assistance in that regard. It is easily understood why the younger a child is the more easily the teeth are moved to the required position. I would like to make another observation having regard to the number of dental students, because that matter has been referred to here several times. After the last war the number trebled; there were three times as many dental students in 1920 as there were in 1918. From all indications we anticipate that the same thing is going to happen this time, perhaps to a greater extent, because we have in the dental corps, as you know, a large number of assistants and technicians who have expressed the intention of going into the profession after the war. This number is much greater than it was after the last war. So that we do not look with fear upon the need for getting personnel for dental students. There is one other observation I would like to make in that regard in reply to the gentleman who has just spoken, and that has to do with the economic condition. We have looked at the matter from the standpoint of health, but it is not so long ago that we had dentists practically on relief, and under those conditions it is easily understood that no organization representing the profession would go out and endeavour to increase the number of students attending school. Now, if that situation is all changed why then it becomes a different proposition; we have not any doubt but that we could go out to the high schools and the various educational organizations and encourage bright students to enter dentistry with no trouble whatsoever. That has not been done in the last twenty-five years in Canada because there was not the appreciation of the condition which demanded the number of dentists to justify us in doing so.

Mr. JOHNSTON: Speaking along the same line, the point raised here on a number of occasions by practically all speakers was that there was a shortage of dentists, and that especially when this social security plan is put into operation one of the big difficulties which we are going to face is the shortage of dentists. I imagine that condition applies also to medicine. Now, someone has said that at McGill it requires one or two years of Arts and Sciences to enable one to enter dentistry; in Alberta it takes two years of Arts to enter dentistry. I am wondering if there is not some way by which we could lower that entrance into dentistry and medicine without affecting the efficiency of the final result at graduation and thereby getting a greatly increased number of students. Now, the economic problem enters into this educational field tremendously. A young person has probably finished high school or has his high school matriculation and he contemplates entering dentistry and then he is faced with the financial problem of two extra years of Arts or the combined courses of Arts and Sciences, and it represents a tremendous added financial burden. I do not think that the other two years of Arts greatly increase his efficiency as a dentist when he is graduated. I think the purpose of that was in past years more along the lines of making a higher standard for dentistry and the same thing for medicine. It seems to me we could overcome this problem somewhat if we lowered the entrance into this profession and instead of making it two years of Arts, cut it down to one year of Arts, and that would be the qualification of entering into dentistry. I may be wrong in this, but I cannot see where two years in Arts, outside of eliminating the number who would enter dentistry, greatly increases the knowledge of the student when he has finished dentistry for dentistry. I am wondering if that could not be done. What is the explanation for that?

Dr. WALSH: I should like to have a nice long chat with my friend here because we feel that he needs guidance in dental education. We have passed through that period. We were once in the position where dentistry was a three-year course after matriculation and then it went up to four, then one and four, and now it is two and four. The reason is this. Biological subjects that are

part of the first and second year of medicine and dentistry have progressed to the point where it is generally recognized that the matriculant is not mentally capable of taking in the knowledge. Just to show you, our dental students with two years of arts and sciences are put in the same classes of bio-chemistry with the medical students who all have three years, and most of them with Bachelor degrees. The result is we have on an average 25 per cent failures and their average is about 5 per cent. If you reduce it to one year we would have 40 per cent; if you took in matriculants none of them would get through bio-chemistry. They are not mentally capable of taking in these courses; they are so severe, and they require more mature minds to absorb the knowledge which you get in organic chemistry, and so on down the line.

Mr. JOHNSTON: In the first year of arts and sciences you do not get a great deal of organic chemistry unless you are taking a course of dentistry. The entrance qualification is not the same throughout the dominion. It has not always been required that the student should have two years of arts and sciences to enter dentistry. In some provinces the student takes two straight years of arts. If it were desired to increase the course in organic chemistry or bio-chemistry or any of these subjects, that could be easily done without making it obligatory that he has two years of arts.

*Dr. GULLETT: Gentlemen, I would like to make the statement that you will never improve the type of dental service rendered by lowering the standard; it will never happen. The other comment that I wish to make is this: I think you are on the wrong track entirely in regard to the standard shutting students out, because we have a larger number of applications, fully qualified students who wish to enter, than we can accommodate in the schools in Canada at the present time.

Mr. McCANN: It is just the difficulty of accommodation?

Dr. GULLETT: That is right.

Mr. MCGREGOR: The subject of municipal clinics was mentioned here, and I should like to ask if the association is in favour of those clinics, and if so, would they become a part of the whole scheme if and when it goes through?

Dr. THOMSON: Mr. Chairman, any subject such as that would have to be considered in the light of the experience of those clinics, of their value or lack of value. When the scheme goes through as a whole it is left to the provinces to devise plans and in the brief I think it says they shall adopt the best plans they think available.

Mr. MCGREGOR: It was mentioned here a while ago in one of the briefs that all action and all treatment should be taken in the dentist's office. I was wondering—

Dr. THOMSON: That would be answered better by Dr. Gullett.

The CHAIRMAN: Dr. Gullett, I have a question for you. Is the inspection in the schools fairly extensive or is it negligible throughout Canada?

Dr. GULLETT: In the larger municipalities, Mr. Chairman, in the majority of the cities there is inspection; only recently has this branched out in the rural districts, and it is only in a small way and I think, as far as I know, only in the province of Ontario and some in Quebec just recently.

Mrs. CASSELMAN: I suppose this will show an inferiority complex because the answer is so obvious. There is no reason why a woman would not make just as good a dentist as a man, is there?

Dr. GULLETT: As I say, we think there are great openings for women in the dental profession and we have tried to encourage those who are interested to come into the profession, as we think there are excellent openings.

Mr. HOWDEN: Apropos of this question of dental students, I should like to suggest to the gentlemen here assembled that if dental students could see a

desirable living ahead of them after graduation there would be no difficulty in getting a sufficient number of students. I would like to have a comment on that statement.

Dr. FORTIER: That question has been dealt with before, but if I may be allowed a further word I would say in the last few months there has been a shortage of dental manpower. If the plan goes through there will also be a shortage of dentists, but in the last years that we used to refer to jokingly as depression years, there was not a shortage of dentists. There were enough dentists, but some of the dentists did not have enough, and there should normally at that time have been a shortage of dentists, because their services were necessary and should have been required; but the overabundance of dentists at that time was due to the economic situation. And I think, as one of you gentlemen pointed out, as soon as this situation is re-established and the young men who are mentally equipped and have the necessary academic qualifications can be shown that they can have an honourable and practical way of earning their living, will flock to the dental schools, providing the dental schools at that time are able to handle them.

Mr. SHAW: It all depends on the degree of economic adjustment we are confronted with after the war.

The CHAIRMAN: On behalf of the committee I should like to thank Dr. Walsh, Dr. Gullett, Dr. Fortier and Dr. Thomson for their very illuminating and helpful presentation. Thank you very much.

Now, we have representatives of the Industrial Hygiene Department. I will ask Dr. Archer to introduce the witnesses.

Dr. ARCHER: Mr. Chairman, Mrs. Casselman and members of the committee, the program which has been carried out by those interested in industrial medicine has expanded so much in recent years that it is fortunate that an opportunity is being given this morning for the presentation of the special features which will be necessary in any scheme of health insurance for industrial workers. We are fortunate in having here this morning Dr. J. G. Cunningham, who is the Director of the Department of Industrial Medicine in the Ontario government. He is also the chairman of the Canadian Medical Association Committee on Industrial Medicine. We also have Dr. Frank Pedley of Montreal, who is assistant professor of public health and preventive medicine, McGill University. Dr. Cunningham will present the statement to you, and these gentlemen are here to answer any questions that the committee may wish to ask.

Dr. J. G. CUNNINGHAM, called.

The WITNESS: Mr. Chairman, Dr. Archer and members of the select committee, we appreciate greatly the opportunity of presenting this subject for your consideration, as Dr. Archer has intimated.

The considerable body of factory legislation enacted since the industrial revolution has been directed mainly to the protection of the health of workers in industry. It took the stress of the last war to precipitate in Great Britain the first organized scientific enquiry on the subject. The findings at that time and since, have emphasized the importance of this legislation in the interests of industry and the country alike.

The first factory legislation directed to the state of *individual* health came in 1911 when periodic physical examination was required in certain dangerous trades to detect early evidence of poisoning, as a safeguard against the failure of mechanical means for the control of dust and fumes. This dates roughly in the industrial health field what occurred in community health; the progress from purely protective measures to the more positive outlook on health—its upbuilding and maintenance. However, its immediate significance rested in the extension of preventive measures beyond purely

environmental considerations, to take account of the physical condition of the individual, which has since characterized health conservation in all age groups. This is important particularly for adults, since such control of general sickness as is possible in this group, lies mainly in early diagnosis and advice, not only for minor conditions, but for such as cancer, heart disease, pernicious anaemia, and diabetes as well. The procedure is more readily applied to groups and herein lies industry's opportunity.

In manufacturing industry alone in Canada, 35,000 employees are absent from work daily on account of sickness. Large additional numbers of persons are at work although suffering some ill-health. There is ten times as much absence from sickness as from industrial accidents—

By Mr. Maybank:

Q. You refer here to 35,000 employees being absent from work daily on account of sickness. Is that the average over a period of years and is that pre-war? Is that 35,000 figure arrived at before 1939, let us say?—A. Yes.

Q. It has nothing to do with absenteeism now?—A. It is higher now. This would apply to ordinary conditions.

Q. This 35,000 would be arrived at by the average over a number of years earlier than 1939?—A. Yes, but an estimate, not absolute.

By Mr. Mayhew:

Q. What percentage of the whole would that 35,000 be?—A. Of the total number of employees?

Q. Yes.—A. If we consider the manufacturing industry alone it runs about 3 per cent.

By Mr. Maybank:

Q. So we can say on the average in peace time we have 97 per cent of the manufacturing activity working?—A. As far as sickness goes.

Q. Ninety-seven per cent of them are well enough to work?—A. Yes.—so that a reduction of only 10 per cent in sickness would be equivalent to the elimination of industrial accident as far as lost time is concerned. Much more than *lost time* is involved, but to some extent it can be used as a measure of what exists.

There is sufficient evidence for the statement that even under schemes for the care of sickness where pre-payment is made, adults do not avail themselves of the services provided as early as is necessary for the most effective control of ill-health. Accessibility and convenience are important as well. Industry and commerce make it possible to bring health services to groups where early diagnosis of disease and defect can be initiated with a view to correction. The procedure is not new, and requires no additional demonstration of its value. Many factories, particularly larger ones here and elsewhere, have instituted these health services. There are about 300,000 employees in such factories in Canada enjoying some degree of health supervision of this type.

The Program

In Great Britain in 1940, legislation provided that the Ministers might require war industries to employ such physicians and nurses as may be necessary for "the medical supervision of persons employed in the factory, and for nursing and first-aid services for such persons." The program does not cover active treatment of disease, rendering only such treatment as may be necessary at the factory. It involves physical examination for guidance in placement at suitable work; encouragement to employees to report to the factory dispensary with minor complaints of ill-health, which, supplemented by periodic physical examination provides opportunity for early diagnosis; observation of the employee at his work and of the

conditions of work during regular tours of the factory, directed partly to the control of occupational diseases; education in health practices; care of accidents, and rehabilitation after accident or sickness in collaboration with the family physician. The term "Health Supervision" is here used to designate this program.

The Employee and Employer

From the employees' standpoint, the general level of health is raised. He receives advice on the need for treatment, and as the benefit of the effort of those in the factory whose definite responsibility it is to safeguard health. The response of employees to such facilities has been nearly always immediate, and large enough to warrant the conclusion that a definite demand exists. The interest aroused in the employee at work influences his attitude to the subject of health in his home.

The maintenance of health in wage earners can only result in benefit to industry; in fact, the costs associated with training new employees, including their higher accident experience, the replacement of those who are temporarily absent and other indirect expense, have been sufficient to warrant many employers instituting such services voluntarily. Close supervision from within the factory is exercised over all conditions of work which may affect health, and better mutual understanding of the problems of employer and employee is engendered, contributing to an improvement in industrial relations.

The Physician and the Nurse

From the medical viewpoint, the opportunity is provided to apply the principles of preventive medicine to personal and environmental health in one of the largest and most productive groups in the community, and to observe closely the development of disease in adults. The industrial physician knows the workman at his work and has access to indications of ill-health at an early stage. He can crystallize the efforts for better health made by voluntary and official health agencies which work from outside industry. In such manner conditions like tuberculosis, malnutrition, venereal disease, occupational diseases, fatigue and maladjustment at work can be observed early and appropriate action taken.

The Community

An increasing percentage of the total population falls in the adult age groups, and the maintenance of health in these depends in a large measure on this early recognition of disease. Periodic physical examination is directed to this end, but its application has been largely limited to its use in industry, partly because here, it can be brought to groups of individuals. The further approach to more effective conservation of health in adults can most logically be made through industry. While a considerable section of the population is engaged in agriculture and other pursuits which do not render them so accessible from this standpoint, the program is no less effective where it can be applied. It is necessary in time of war, when the number of women and of handicapped workers employed is much greater and when maximum effort is invoked, that this "running" or day to day supervision of personal and environmental health should exist, but it should be continued into the post-war period to a still greater degree than may be possible at present, considering the availability of medical personnel.

Health Insurance and Industrial Health.

It is important that the program for health supervision in industry be closely integrated with any provision for National Health Insurance. Industrial medicine undertakes to maintain health in a large section of the

adult population. It is essentially a preventive service carried out mostly by practicing physicians working in industry on a part-time retainer basis. The industrial physician initiates measures conducive to good health. He is diagnostician and health officer to the factory group. Upon access to this group depends his usefulness in this capacity. This access has been limited. Health insurance enactments elsewhere have taken no account of this, partly because industrial medicine has had its greatest development in recent years. It is looked upon as a service which should be developed by industry itself, with suitable technical advice.

Section 5 of the Draft Bill indicates that the statutory provision regarding public health shall include activities enumerated in Schedule 3. Schedule 3 under the heading of "Industrial Hygiene" includes "supervision of medical and nursing services relating to the health and welfare of industrial and other workers." There is, however, no clause in the "Bill" ensuring that these medical and nursing services will be provided. At present their provision depends upon the individual employer's interest and insight into the value of maintaining the general health of employees, even though wages cease when the workman is absent on account of illness. The same considerations govern also the adequacy of the program carried out, so that marked variations occur in the amount and kind of medical personnel used for preventive purposes in relation to the number of employees.

Recommendations.

1. That special provision be made whereby the maintenance of health and the control of general sickness of industrial workers are closely integrated with any health insurance plan adopted. This is additional to the treatment of disease when it supervenes, and to the protection for employees afforded by existing Factory and Workmen's Compensation Acts.
2. That all industries with more than one hundred employees be required to establish and maintain medical services for the improvement of health.

Federal Order in Council No. 1550 under authority of the War Measures Act, now requires that in any war industry under contract to the Dominion Government, there shall be "medical, surgical, nursing and preventive services" to the satisfaction of the Minister.

It is desirable that those working in factories and elsewhere, in groups of less than one hundred employees, receive similar benefit as it becomes practicable.

3. That this health supervision provided by industry meet the requirements of the provincial health authorities on such matters as the extent of the program, the use of trained personnel, and securing the confidential nature of medical records.
4. That a part of the medical cost of health supervision in these groups of workers be paid, on a per employee basis, from the Health Insurance Fund, to each employer who meets the requirements. The benefits to be derived are not limited to industry, but extend to the community as a whole.

5. That these provisions be incorporated in the Health Act.

Dr. PEDLEY: I would like to underline briefly some of the statements which Dr. Cunningham has made. First of all we all appreciate that medical science is very rapidly developing and that diseases are now coming under control which a short time ago were not controllable at all; for example, diabetes is now a controllable disease and the same is true of pernicious anemia. We have the new sulfa drugs which have brought another host of diseases under control. In the

past health has been directed with major emphasis to the child, the pre-school child and the school children, but as the population is becoming older and older—and Dr. Haegerty will confirm this—more people are now in the older age groups than formerly—adult health becomes increasingly important.

Now, what Dr. Cunningham has been trying to stress is that industrial hygiene is essential to adult health. In the prevention of disease among adults the essential factor, the most important factor, is the periodic health examination. The medical profession has stressed the periodic health examination. But in actual practice we can say that the only places where periodic examinations are made to any extent are in industry. Therefore, if we approve of periodic health examinations as a method of improving adult health we should encourage the places where periodic examinations are being made, and that is in industry. It is only in industries which have well developed medical services that these periodic health examinations are being made, and it is our belief that this Health Act should further the development of those medical services so that more of these periodic health examinations may be made.

MR. McCANN: Should you not include the periodic health examinations of insurance companies?

DR. PEDLEY: Yes; but incidentally that periodic health examination does not apply to the whole of the low paid wage earner; it applies to insurance policy holders who have more than \$5,000 insurance, and that is a relatively select group.

Just to specify what we think adult health supervision can do in concrete terms, we think it is perhaps the best locality now for a tuberculosis prevention program. We have noticed that in this country and in the United States the big emphasis on tuberculosis prevention is being developed through the extension of facilities in industries. Then there is venereal disease. With education many industries now are requiring routine adult tests for their workers. We hear of large numbers of cases of venereal disease that are being dug up; think how many more could be found if the service were on a larger and much wider scale than at present.

The whole question of cancer prevention, the essence of cancer prevention, in addition to the education of the public, is the early education with regard to cancer, and it is in the industrial group where cancer prevention can be a factor.

And now, there is heart disease. We do not know much about the prevention of heart disease; we hope to know more, but if we are to know more and be able to apply our knowledge it has got to be through group application, and industry is the only place where you find groups of adults.

Such diseases as pernicious anaemia are extremely important. If we can find pernicious anaemia in its early stages we can prevent its serious manifestations, and the same thing is true of diabetes.

Then there is that whole question of which we hear so much to-day, nutrition. It is in the industrial group that a knowledge of nutritional needs can best be applied. These remarks are simply an amplification of those of Dr. Cunningham.

MR. MAYBANK: Mr. Chairman, at some time we will have to add up the cost of recommendation No. 4. Have you any suggestion to make as to the cost to the fund of paying something to all of the employers to meet such and such requirements. Has that ever been worked out?

DR. CUNNINGHAM: The cost of the type of health supervision which you have attempted to describe for groups—except for the smallest group—it becomes more expensive when the group is small—would average on the whole around \$5 a head a year, and to cover a million employees it would cost \$5,000,000 to do it.

Mr. MAYBANK: Suppose that at the present time A B C company manufacturing, shall we say, pitchforks, if you like, is giving this sort of service, and the \$5 per head goes into the cost of the pitchforks or tends to, and if the government were making a contribution of \$5 a head to the A B C company because it did give this supervision, then the company would be relieved of that and consequently would not be put to the cost of the pitchforks. The world still pays for the cost of that, would you not think, doctor?

Dr. CUNNINGHAM: As a matter of fact, it is important with provisions of this kind, it seems to me, that this sort of thing should be country-wide because of the competitive factor, but the idea in the report itself was apart altogether from making it country-wide; it was important to provide some incentive for the carrying out of such a program as I have indicated. Already many employers carry this out themselves without compulsion, but the employer's interests as well as that of the employee is very important in accomplishing a good deal.

Dr. PEDLEY: The importance of this service is two-fold. It is important to the pitchfork company because the pitchfork company has certain values accruing to it and you do not actually raise the cost of the pitchfork by \$5. The prevention of disease would effect a saving in the operation of the pitchfork company's business, but it is also an improvement and an even greater improvement to the country as a whole in the prevention of disease.

Mr. JOHNSTON: As the industries operate now do they pay the doctors themselves on a salary basis?

Dr. CUNNINGHAM: The industries that are carrying on a health supervision program as apart from some group arrangement for treatment operate almost entirely on a retainer part-time salary basis.

Mr. JOHNSTON: What do you mean by "part-time salary", part-time salary and a portion of their regular fee for certain services?

Dr. CUNNINGHAM: No; as long as the program is limited to supervision of health and not active treatment of disease in nearly every case they carry on directly on a salary basis; but because the great bulk of the industries in the country are small it is usually a part-time position involving a retainer or a part-time salary and he carries on with his practice as well.

Mr. MAYBANK: As a rule it is not paid for by the employee making a contribution; it is usually merely supervision, not treatment?

Dr. CUNNINGHAM: That is right.

Mr. MAYBANK: It comes out of the treasury of the company as a rule?

Dr. CUNNINGHAM: Paid for by the employer.

Mr. VENIOT: Mr. Chairman, would Dr. Cunningham be good enough to give the committee an outline of the program of industrial medical services showing the staff that is required and what activities are recommended.

Dr. CUNNINGHAM: Perhaps Dr. Pedley would do that.

Dr. PEDLEY: Briefly, Mr. Chairman, the program consists first of all of pre-employment examinations or, as we call it, pre-placement examinations, to determine the physical capacity of the man to do the work he is expected to do. It is not, incidentally, expected to rule out the man for employment, but it is intended to supply him with an examination, a very thorough examination including X-rays of the chest and blood tests and so forth; secondly, it provides first aid and accident service, because industries come under workmen's compensation and are responsible for accidents. Thirdly it provides for periodic examination of workmen; and fourthly it may supply consultative service for early diagnosis of diseases that need treatment. It usually provides nursing service, but the procedure varies. It provides a careful inspection of the plant with respect to sanitation conditions of work and any actual occupational

hazards that may exist, and it provides an educational service, a health educational service to the employee. Now, with respect to staff, it has been estimated it would require the equivalent of one full-time doctor for every 2,500 employees, or two part-time doctors for the same number, and one nurse for approximately every 500 employees. When an industry gets larger clerical staff may be necessary as well.

Mr. KINLEY: How large should an industry be to require the full-time service of a medical practitioner?

Dr. CUNNINGHAM: Mr. Chairman, for health supervision, not for the treatment of employees—I am trying to make a definite distinction between running supervision and health along the lines of the program described by Dr. Pedley and the question of group arrangement for treatment. They are two different things. For general health supervision under ordinary conditions, one full-time physician would care for about 2,500 employees. Under these conditions where physicians are less easily obtainable, the suggestion was made that one physician undertake the care of 3,000. Now you are getting into difficulties as soon as you are getting into special wartime disease hazards or where the labour turnover is very high our position is difficult in handling 3,000.

Mr. KINLEY: With regard to compensation, this, of course, is a provincial matter, and it will apply to the province of Nova Scotia. In Nova Scotia compensation is paid for by the employer, and the men do not pay but they only receive a percentage of the wages from the compensation board when they are ill. In other words, it is estimated that a workman makes his contribution by the fact that he takes less when he is sick than when he is well. You can readily understand that when a man is ill he needs more than when he is well, and I think one of the great weaknesses of our Compensation Act is that a workman when he is ill only gets a percentage of his wages. Now, the province pays the doctor under compensation and the workman can choose his own physician or surgeon—not so much his surgeon with regard to special services, because I think the board chooses a surgeon when the man needs special treatment—but you can see the need for co-ordination when you have compensation in an industry and when a workman goes to his own physician and where the state pays the doctor and where in the case of health services in industry would have a doctor of its own and would pay that physician; there you would have two different people dealing with practically the same subject.

Now, in your presentation you rather spoke against part-time work by a doctor, but in small communities it is a matter of serious concern because it is difficult to divide the work in the natural way, and the doctors of the communities have all kinds of difficulty if you chose a doctor who is not the doctor of the family of the worker. Therefore, you make the statement that the state should pay some of these. At the same time in the case of the work of the Compensation Act where the workman pays nothing but takes less, they all are paying into the pool and the workman should be compensated even a little more when he is sick because he needs compensation more. In our scheme of social security this matter of compensation is one that will have to be dealt with.

Dr. BLACKLER: I have a figure here which I should like to leave with you. The number of workers in industry in the last available statistics was 1,800,000. They are working full time, but there are a number of part-time employees, and 75 per cent of those are in plants of 100 or more, and these people or individual workers in the plant represent families of approximately three in number. The importance, therefore, of the individual in the factory carrying home information on health education cannot be minimized.

The CHAIRMAN: I should like to express the thanks of the committee to Dr. Cunningham, Dr. Pedley and Dr. Blackler for their presence here to-day and for their presentations.

Mr. SHAW: Before we adjourn, Mr. Chairman, I would like to ask if it would not be possible to have these briefs in our hands prior to the time of meeting. When these briefs are given to us at the meeting we have some difficulty in looking over them as closely as we might desire while they are being read. I realize that that might be difficult at times, but I throw out that suggestion.

The CHAIRMAN: I think it would be desirable if we could do it, but it is not always easy to have it done. We will do the best we can about it.

The Committee adjourned to meet Friday, May 14, at 11 o'clock a.m.

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SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 10

FRIDAY, MAY 14, 1943

WITNESSES:

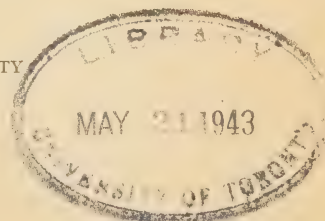
- Dr. Ernest Couture, Director, Division of Child and Maternal Hygiene,
Department of Pensions and National Health, Ottawa;
Dr. John Puddicombe, Obstetrician, Member of Scientific Advisory
Committee on Maternal Hygiene;
Mr. H. H. Hannam, President, Canadian Federation of Agriculture;
representing the Health Insurance Committee of same.

OTTAWA

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PRINTER TO THE KING'S MOST EXCELLENT MAJESTY

1943



MINUTES OF PROCEEDINGS

FRIDAY, May 14, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Bruce, Casselman (Mrs.) (*Edmonton East*), Cleaver, Cote, Donnelly, Fulford, Gershaw, Gregory, Howden, Johnston (*Bow River*), Kinley, Lockhart, Mackenzie (*Vancouver Centre*), Macmillan, McCann, McGarry, Mayhew, Picard, Shaw, Slaght, Veniot, Warren, Wood, and Wright—26.

Dr. J. J. Heagerty, Director of Public Health Services, was called and introduced the following witnesses:—

Dr. Ernest Couture, Director, Division of Child and Maternal Hygiene, Department of Pensions and National Health, Ottawa;

Dr. John Puddicombe, Obstetrician, Member of Scientific Advisory Committee on Maternal Hygiene;

Dr. George Campbell, Specialist in Children's Diseases; and

Dr. Lloyd P. MacHaffie, Health Advisor to Ottawa Public Schools and member of Scientific Advisory Committee on Child Hygiene.

Dr. Couture was called, presented a brief dealing with Child and Maternal Hygiene, and was examined by the committee.

Dr. Puddicombe was also called and examined.

The chairman thanked the witnesses, who then retired.

Mr. H. H. Hannam, President, Canadian Federation of Agriculture, and representing the Health Insurance Committee of same, was called. There being insufficient time for Mr. Hannam to present his brief, Mr. McCann moved that the pamphlet intituled "Health on the March", which had been supplied to the members of the committee, be printed in the evidence, and that Mr. Hannam be given an opportunity later to present the brief which he had prepared. Motion adopted.

The above-mentioned pamphlet is printed in this day's evidence.

The committee adjourned at 12.40 p.m., to meet again on Tuesday, May 18, at 11.00 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

May 14, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: This morning we shall discuss child and maternal health. I shall ask Dr. Heagerty to introduce the first representative.

Dr. HEAGERTY: Mr. Chairman, ladies and gentlemen, the first speaker this morning is Dr. Ernest Couture, who is the chief of the Division of Child and Maternal Hygiene, Department of Pensions and National Health. Dr. Couture has been dealing with the question of morbidity and mortality connected with the child and the mother for many years from a national standpoint and is well qualified, therefore, to appear before this committee. He has associated with him certain men who are outstanding in this field. I might introduce to you Dr. George Campbell, well known child specialist; Dr. MacHaffie, who is also a child specialist and is a member of the Advisory Committee on Child Hygiene for the Department of Pensions and National Health, and also adviser to the Department of Education for the city of Ottawa on child welfare, and Dr. John Puddicombe, obstetrician, who is with us generally but occasionally takes a flight into royalty.

The CHAIRMAN: Dr. Couture, will you proceed, please?

Dr. ERNEST COUTURE, Director of Child and Maternal Hygiene, Department of Pensions and National Health, *called*.

The WITNESS: Mr. Chairman, members of the Committee:—

The establishment of a plan of social insurance at this hour when it would seem to us that it is only possible to think of the events that follow one another in quick succession overseas gives proof of very great wisdom. One must prepare for peace by the means associated with peace. I have reason to believe that I am called upon to contribute to the formulation of a vast programme of social welfare. I also feel that in my capacity as chief of the Child and Maternal Hygiene Division I am working for the families of to-morrow. It is to Canadian society that has its birth and being in the family that we undertake to bequeath reforms that will spread benefits for long years to come.

As French Canadians, we owed it to ourselves to share in such a project. If I must present my study in English, it is in order to meet requirements of a practical nature and make this study as effective as possible.

By reason of the too-limited time made available to me, French copies of the text you have in hand were not ready for distribution at the moment. However, I shall be pleased to forward them to you shortly.

Mr. Chairman, and members of the committee: I wish you to know that, as Director of the Division of Child and Maternal Hygiene in the Department of Pensions and National Health, I appreciate greatly the opportunity to represent the interests of Canadian mothers and children before the members of the House of Commons committee on the project of health insurance. I do hope that my contribution will help not only to foster the well-being of those I am called upon to serve—Canadian mothers and children—but also to establish the basic data and outline a solution in regard to my own field.

It is worthy of attention to note the progress accomplished in Canada in past years. I wish to recall briefly the salient accomplishments which will serve as the demarcation line between what exists and what is still to be done. Statistical data since 1926 will convey sufficient information. (This is the first year for which we have figures for Canada as a whole.) In 1941 the improvement in the maternal situation has been manifested by a decrease in mortality of nearly 38·6 per cent on the 1926 rate. The infant mortality rate shows a reduction of 41 per cent for the same period.

Among the various factors accounting for the progress in both the maternal and child situation, I believe that the intensification of educational efforts initiated by Dr. Helen MacMurchy in 1920 as head of the Child Welfare Division of the Federal Department of Health, and carried on increasingly ever since, deserves special mention. The amelioration must be credited also to the progress achieved in the sciences of obstetrics and pædiatrics. Other factors must be mentioned—prenatal clinics and well-baby centres have been multiplied, hospital maternity services have increased and improved, the principles of hygiene have become better known, and a greater number of sanitary measures have been more generalized. Lastly, the admirable work carried on by the special provincial set-ups in their rural sections (health units, municipal doctors, and the distribution of health services by districts.)

I have been greatly impressed by the change in the conceptions of the public on health and hygiene. This change has been brought about, without any doubt, by many events of this war. In the past three and a half years attention has been focussed on physical fitness through the many thousands of physical examinations, through magazine and newspaper articles on nutrition and the benefits of a well-balanced diet to build health and offset the wear and tear of these trying times. These and many other facts have brought the people to their toes in matters of hygiene and, consequently, mothers could not but participate in this new movement towards better physical being. As a result the interest given to the outcome of pregnancy and the health of their babies is remarkable. The steadily increasing volume of correspondence reaching our office, and its character, attest to this fact. The demand for our publication—*The Canadian Mother and Child*—is increasing to such a proportion that it seems impossible to meet it. These realizations are very gratifying as they prove that the efforts made by public health agencies have been amply repaid.

However, upon closer study it becomes apparent that our end has not yet been attained. This succinct view of the results obtained show us clearly that our efforts have met with some success. A statistical approach only to the problem would not have recorded the situation in its true light; many effects must be attributed to indirect causes, to causes beyond our immediate control and, hence, only partially due to our merits, but I must insist on this, that our past accomplishments should give us heart to pursue in our already established services and in new fields. Moreover so, since comparisons with other countries make us see that we have not expended all our resources and have certainly not applied all our efforts. We must then believe that, as regards maternal mortality, we can accomplish as much as England where the rate is over 25 per cent lower than ours, and as much as the United States whose infant mortality rate of 45 in 1941, as compared with our rate of 60 per 1,000 live births, is 25 per cent lower. The accomplishments of these countries should not be an impossibility for us.

The generalization of the rates for Canada would tend to show our situation in a brighter light than it really is, as the results of the various provinces are greatly unequal—the maternal mortality rates ranging from 2·7 to 4·3, and the infant mortality from 37 to 80. The same might be said of the large cities where the rates are very divergent—offering a minimum for maternal mortality of 2·1 and a maximum of 7·0, and the infant mortality rates a minimum of 24 and a maximum of 95.

A second argument to prove that our deficiencies are yet remediable is that the percentage of the total maternal mortality due to puerperal sepsis, toxæmia and hæmorrhage is 60 per cent. These are three conditions which are recognized as being preventable or amenable to treatment.

Then, so far as the infant mortality is concerned, premature birth, pneumonia, influenza, bronchitis, diarrhoea and enteritis, injury at birth, diphtheria, tuberculosis and syphilis—account for over 60 per cent of all deaths in the first year of life. These conditions are in the same class as those referred to above, that is, they are preventable or amenable to treatment.

So far we have referred exclusively to mortality as being the sole indicator. Although morbidity is not a factor which can be determined as exactly as mortality, yet we must consider it as an important criterion in the determination of the extent of the problem.

Some authorities claim that one out of every ten mothers suffers some invalidity following childbirth. Basing our calculation on this estimate we can see that out of an annual 90,000 first births or pregnancies (approx.) some 9,000 mothers suffer some disability.

And according to estimates of school medical officers, between 50 and 75 per cent, which are conservative figures for certain centres, of children entering school suffer from minor or major physical or mental defects.

Why such a wastage of life and health?

Many letters received in my office too often report that required services are not available, or that necessary precautions are out of the correspondents' means.

We have in the rural sections of the country very effective means of controlling or improving the public health of the people, but these health units have not as their attribute the attending of confinements, so that the mothers living in isolated sections of the country where there are no doctors are unable to obtain from these services any kind of help, and that applies to a good many in Canada. Do we not find in this the main reason why there are annually some 20,000 mothers without the attendance of a physician at the time of the birth of their babies.

Another evidence of the inadequacy of the services insofar as maternal and child hygiene is concerned is afforded by reports covering the activities of the provincial and municipal departments of health. I might refer in more detail as to the various set-ups in the provinces throughout Canada. Two provinces have divisions under the direction of medical men. Some of the provinces have these divisions now under the direction of a nurse while some of the other provinces have no such divisions at all; this particular field of hygiene is looked after by the medical officer of health of the province and you can readily understand that with all his other activities he cannot hope to cope with this problem in anything like an efficient way. Also spot studies of the various regions bring us to the same conclusion; services are very unevenly distributed. This, of course, is to be expected in view of the diversity of conditions in the different provinces and municipalities. Notwithstanding this fact, we have evidence that they are, nevertheless, limited in their means of action. In one word it might be said that the services are patterned more according to financial capacity than according to need.

Now much could be said on the lack of appreciation of the value of services on the part of the population as playing an important role in delaying the development of public health services. Perhaps publicity and education have not been ample enough to convert people to accept many of the necessary facilities.

We must admit that health services have done admirable work in gaining control of epidemics and diseases which, in the past, were playing havoc among the population. We have succeeded, for instance, in eradicating smallpox, in eliminating practically all typhoid epidemics, in reducing the number of victims

of scurvy and rickets, and in preventing the spread of many of the communicable diseases, in lessening the toll exacted by tuberculosis, etc. We are still engaged in the fight against all of these diseases and in a more precise way actually against diphtheria. Recently we are trying to solve the problem of cancer and of venereal disease. These are some of the activities which absorb the various health agencies so that we have, up to now, tried to find the immediate solution to our more urgent problems; therefore, one can understand how child and maternal hygiene could not receive the attention they deserved.

Having perceived that our problems must be solved at their source and not only in their ultimate manifestations we believe that a definite programme respecting child and maternal hygiene should be adopted. This programme should reach all of those regions where Canadian interests are involved.

Up to now everyone had been concerned with his own local problems, but we require provincial collaboration because in such a way we can reduce the cost of health services and go deeper into the root of the problem. As has been seen in the past the federal services have helped greatly the cause of the Canadian mother and child. In any project we have to figure on their use and their great opportunity. Such a central organism can obtain from other countries statistical data and procedures which will show us how we stand and how we can improve our situation. I have here evidence of this advisability of a central service through this communication from New Zealand, for instance; we have been in constant communication for years; I know what they are doing and they are inquiring into what we are doing. I think a central organization for the interchange of ideas and information is very desirable; otherwise, it would mean that these foreign countries would have to communicate with some nine agencies individually where it can be done through a central organization for the benefit of all.

In the same line of thought statistics rendered available by this organization will be more representative and, by being centralized, avoid each province repeating all the findings. It can make studies covering the whole country and fact finding in localities where results show extreme reaction so as to know when to apply and when to avoid certain methods. Also all of this data may influence medical thought and the medical viewpoint throughout the country so that study courses or efforts be directed towards the solution of problems involved. I might point to the influence or to the effect of investigation in its relation to the possibility of improving the services. We have a very fine example of what is being done along this line in Chicago: Dr. Bundeson is the health officer for that city; he investigates every mortality in the city of Chicago, which as you know comprises a population equal to one-third of the population of the whole of Canada. Every single mortality is investigated, and in the light of the evidence he sometimes orders an inquest. One direct result of these enquiries is that they are able to allocate the responsibility or the factor accounting for death, with its object of correcting these factors when possible. As a result of this work or of his investigations, the infant mortality in Chicago is down to 28 while ours is 60 per 1,000 live births. A certain central organism can serve as intermediary for all our health or social agencies, some exercising their activities in some provinces, others in many or all. Again what we need is a central body to coordinate the interests of the community with those of the Canadian medical profession. We have many occasions for communicating messages to the practitioners through the means of *National Health Review* or some special publication prepared for a particular purpose. With the consent of the provincial authorities it can introduce certain measures which, while advantageous, may at first meet with some opposition on the part of the people and thereby making the local authorities unable to initiate them.

This has been the experience in one of the provinces where we have been trying to establish health units in the rural sections of the country. They met with a lot of opposition in some sections of one province but it was established

notwithstanding this opposition, through means coming from outside, so that the population could not criticize the outlay or expenditure for such a service for which they were not favourably disposed. This help from outside sources is available to them for a period of three years and it is very seldom after it has been in operation for a period of that length of time that they allowed it to be discontinued.

Lastly, many types of publications, such as, for instance, those dealing with standardization of care and with problems on a national scale, can be dealt with conveniently only through a federal distribution centre.

I have here a study prepared in collaboration with the vital statistics division. It is entitled, *A Study in Maternal Neo-Natal Mortality*. Publications of this kind have been found very useful by teachers of hygiene who distributed them to their students.

A plan implying the cooperation of the public cannot be successful without a sound campaign of education, since education only can have the people accept and make use of that which is to their welfare and which requires individual consent. Publications must be made available in generous number even without fear of overlapping as it is through constant repetition that the public will eventually be impressed. The variety of these publications must be such as to attract everyone.

Messages appearing regularly in the daily papers are now recognized as one of the best means of publicity due to the importance which the press has acquired. Another publication covers both statistical data and factors study. This was quite an elaborate study; the end results prove very useful as it revealed its necessity of investigating further many of our conditions. Among other findings it showed that concerning the problem of maternal mortality further investigations were necessary. I might point to one experience of Dr. Bundeson. Distributors of particular food products used daily paper notification of births to trace the mothers and impress them with the value of these particular foods; and as a consequence of this pressure only 40 per cent of mothers were nursing their babies. Dr. Bundeson asked the cooperation of the daily papers through not publishing the births, and instead of the distributors of food products contacting the mothers his nursing personnel were the first to appear on the scene and thereby increased the number of mothers nursing their babies by some 15 or 20 per cent inside of a few months. That is an indication of what the daily newspapers can do in influencing favourably or unfavourably a particular problem. We can and should make use of daily papers more generally.

One method which we have been lax in adopting in Canada and yet one which serves to focus the attention of the people in a very striking manner on the vital subject of maternal and child health is the distribution of films. Films in connection with maternal hygiene—would be well worth while. There is not enough distribution of films of this type. As an illustration of this fact I might refer to the results obtained in presenting the film, "The Birth of a Baby". Within eight months some 750,000 people have seen this picture, and their reaction proves its influence and their interest.

We used to post a nurse in the lobby of the theatre in order to inform the public of the services in their locality or to answer questions pertaining to hygiene or for the purpose of distributing literature. One nurse, during one session after one representation, was informed by twenty-five mothers that they had realized how neglectful they had been in not obtaining medical care earlier during pregnancy. Some were in their fifth, sixth or seventh months of their pregnancy and had not contacted their doctor yet. This picture showed to them the importance of this attention; it made them realize how neglectful they had been. If this film has done so much in one centre within a few hours you can imagine its influence in Canada as a whole.

In the same way we should have recourse to the radio as a means of propagating indispensable principles. I am not referring to addresses given over the radio, but to programmes of an educational yet recreational aspect.

We have still to use more extensively the most potent weapon—personal contacts. I referred to that measure in connection with Dr. Bundesen's experience with nursing. I might say that on the last page you have a table which shows the reactions in two counties in New York state. The table shows the improvement realized through personal contact. I am referring to Kingston and Auburn counties; to increase their personnel, social security funds were used for this purpose. After the birth of a child a doctor inquires into the type of pregnancy, the birth, the post-natal conditions; a record is kept of these data. They have a special form and then a nurse contacts the mothers and follows the babies regularly until school age. The results obtained through this activity are recorded in the table referred to above.

Personal contact can be effected only if trained nurses are available. All provincial authorities recognize their dire needs in this respect.

I have emphasized education because in the past we seem to have failed too often in obtaining the response of the public in many fields. For instance, the Manitoba Pregnancy Survey carried out in the years 1938, 1939 and 1940, has revealed that only 25 per cent of the mothers availed themselves of the recognized minimum of prenatal care. On that basis some 195,000 mothers yearly are without the full benefits of this essential attention. Also, although immunization services against diphtheria have been given gratuitously since 1926, some centres record only about 60 per cent of the children as protected.

We probably have not succeeded because we probably have not used the means. One centre last year, during a campaign in favour of toxoiding children, increased the number of children being toxoided from an average of 50 to 100 a month to 1,000 to 1,200 a month. This proves what can be accomplished through very definite efforts.

Diarrhœa and enteritis accounted for 1,693 infant deaths during 1941. The existence of this condition in large measure is characteristic of a lack of the application of hygienic principles. Therefore, this large number of deaths would seem to indicate that we have failed to impress a good many mothers regarding these principles.

There would seem to be a constant need of demonstration centres which could establish standards in relation to personnel requirements or the practicability of certain measures.

For instance, we cannot determine the number of nurses that are required in each locality unless judged in the light of what appears to be the requirements of other centres showing somewhat similar conditions. In certain localities one nurse for every 7,000 population has been found to be sufficient while in some others we have one nurse for every 10,000 population.

Many problems relative to pregnancy and child well-being are still unsolved. Provision should be made to encourage research along these lines through grants to university laboratories or through the introduction of special services in the provincial and federal laboratories to deal with these specific problems.

At the present time there exist very limited facilities for refresher courses for public health personnel engaged in the field of maternal and child hygiene. Great benefits would be derived through a more generous treatment of the personnel in this regard. I might say that New York is practically using up most of its appropriation, most of its grant from social security, in establishing centres for refresher courses so that they know of the importance of this particular effort.

For instance, the successful treatment of prematurity is intimately dependent upon expertness in nursing care, and such expertness is acquired only through special studies.

The problem of maternal and child care in rural sections of the country is a very complex one in Canada. With poor means of communication and transportation, and having to face the rigorousness of our climate, a limited personnel and facilities cannot render services to everyone when a population of only 5,254,239 is distributed over a territory covering no less than two million square miles.

One can appreciate the extent of the problem only when one knows that 38 per cent of all births, that is 96,634 babies, were born in 1941 to mothers living in the country.

Public health services deal in hygiene and so, with very few exceptions, have not considered it their responsibility to care for mothers at the time of birth. I suggest that this conception be revised.

I refer you again to this table on the last page. St. Lawrence county have as their main object the qualifying of a number of nurses who would attend confinements and help thereby the limited number of doctors in these sections of the country. You can judge of the results obtained through this measure by glancing at the table on the last page.

In Canada, then, the question of maternal care in the rural sections deserves first place in any health scheme. One solution might be the offering to the medical profession of the assistance of nurses especially trained in obstetrics, and the distribution of maternity homes in the most strategic positions.

A second step to be accomplished is the recognition and the adoption of minimum standards in our obstetric and paediatric hospital services. There was a survey made of the hospitals of one province and it reveals the fact that we do need to have some special standards. For instance, so far as wearing masks in the hospital services fourteen out of twenty-six were not using masks. There were fourteen out of twenty-six hospitals where this measure was neglected. I am just going to point out three or four deficiencies. There was also the question of the staff and formula room. Out of twenty-six hospitals ten of these institutions were found to be very deficient in that respect. Then with regard to the technique of the warming of infant feedings and so forth, fifteen out of twenty-six were found to be deficient. Even the matter of diapers was investigated and out of twenty-six hospitals sixteen were found to be unsatisfactory. With regard to the care of premature babies, the cubicles, the layout of the service, eighteen out of twenty-six were found to be deficient. I think that in the light of these findings there is evidence of a need of standardization of hospital maternity services.

Clinics should adopt a uniform routine in the matter of prenatal care. An investigation carried out by a certain officer of health in the United States concerned over the fact that the people were not patronizing the clinics to the extent they should found that the main reason was that the mothers felt they were not getting the attention they thought they required. That there was neglect in the attention they received. The reason for that situation is the difference in the methods of different clinics. The medical profession should be made aware more generally of the recommendations of the committee on maternal welfare of the Canadian Medical Association concerning the recognized minimum standard of prenatal care.

Many studies concerning nutrition in pregnancy have demonstrated the profound influence it can have in the processes of child birth. A more equitable distribution of food products, their greater availability, and a better understanding of their value seem to be indicated.

I have referred previously to puerperal sepsis as being one of the major causes of maternal mortality. Not only that, but its crippling effect would make it advisable for any health services to provide drugs which prove to be specifics. We have at the present moment the sulpha drugs. A precedent exists in this regard since public health services furnish for administration drugs intended for the cure of syphilis, and radium for the treatment of cancer.

Another factor of which I have spoken, which is responsible in the determination of our maternal mortality and for the poor health of many mothers, is haemorrhage. If the Manitoba pregnancy survey is a criterion in appreciating the situation in Canada as a whole, and I do not doubt that this is the case, it

would denote that we do not take heed sufficiently of transfusions. This survey revealed that out of nine mortalities which occurred in hospitals only one mother had had the benefit of a transfusion. The provision of blood banks would permit a more general use of this measure.

So far as children are concerned, the following approach to the reduction of our infant mortality has given marked results. Prematurity is the chief cause of infant deaths accounting for nearly 25 per cent of all deaths in the first year of life. In addition to the need of focusing the attention of the nursing profession and of the general public on this topic, the provision of incubators would seem to be our most effective means of satisfying this purpose. The distribution of incubators throughout the country, either for the treatment of the infant at home or for transportation to the hospital, would no doubt go a long way in reducing the toll from this cause. According to Dr. Hamblin of Toronto, if the temperature of the premature baby is maintained above 96 degrees its chances of survival are enhanced eightfold.

Human milk depot is also found to be a life-saver in the treatment of premature babies. A human milk depot exists at the Royal Victoria Hospital, Montreal, and its outstanding results prove not only that this measure is practicable but also that if these depots were provided in sufficient numbers they would no doubt be a valuable asset in the reduction of mortality from prematurity.

Whenever indicated the sulpha drugs could be had recourse to by public health services in cases of influenza and pneumonia which, in 1941, answered for 2,930 infants.

Pre-school age children are engaged in a period of their lives which is extremely significant since it is during this stage they are laying the foundations of their future health. This group should be regularly followed by physicians or in clinics so as to prevent or remedy all conditions, serious or otherwise. Records must be kept of this group to facilitate the work of school health officers. These documents would be analysed under the light of well-defined norms recognized everywhere and applying both to the mental and physical health of the children. This group has been the most neglected up to now.

We should also establish the same services in all schools. They do exist in a rudimentary form but require an amplification. Everywhere regular examinations should be made and recorded so as to follow every school child. But we should not be content with these negative measures favouring prevention only, but we should also foster physical education through the teaching of hygiene, the encouragement of sports, and the establishment of vacation houses where children may get their quota of sunshine and open air. Such a picture would not be complete without a psychologist who would deal with all special problems of school children and when the time is ripe introduce vocational guidance.

Juvenile delinquency is actually taking on the form of a sore. Social workers, devoted entirely to this question, could re-habilitate these misguided young persons.

Such a programme must be paid for. The cost it represents can be met only if a proportion of the health budgets are expended exclusively for these purposes. This proportion could be determined by an inter-provincial conference which would take into consideration the needs of the provinces and establish a ratio thereon. Without such precautions it would be seen, as in past years, that all the appropriations will be used to solve ever-recurring problems of great urgency at the expense of this long-term plan having precisely as its end the minimizing of the future recurrence of our actual problems.

May I repeat that this programme has been designed to tackle the problem at its source instead of meeting it at its final onset? All this is in accordance with the first of the six principles underlying the health insurance plan, and

proposed by the Honourable Ian Mackenzie, namely, "that no scheme of health insurance can be successful without a comprehensive public health programme of a preventive nature."

A perusal of the 62nd Annual Report of the Department of Health of the State of New York will bring us to the demonstration of the great value of any special project concerning child and maternal hygiene. The comparative data* presented in this report would lead us to believe that if a similar project were adopted in Canada it would give results of a great national significance.

Sociologically the family represents the most potent institution. To favour it is to favour and protect all our society. This assertion could find no better demonstration than the dramatic illustrations brought forward during this war. We cannot but hope to see a programme of national importance being implemented to protect the health of our families. Moreover so, since the number of births occurring in the course of five years constitutes one-tenth of our total population. Hence I foresee the application of this programme as having the most profound repercussions on our social and national futures.

Social Security has given the following results in New York State
(In force since 1936)

—	Kingston			Auburn			St. Lawrence County		
	Mat. Mort.	Infant Mort.	Still B. rate	Mat. Mort.	Infant Mort.	Still B. rate	Mat. Mort.	Infant Mort.	Still B. rate
Average annual rate:									
1931-35.....	62.1	68.7	40.6	76.1	40.4	29.3	53.5	70.8	41.9
1936-40.....	49.3	46.1	26.6	39.2	28.5	23.9	44.6	54.9	36.9
Annual rates:									
1936.....	104.0	56.0	26.0	83.0	42.4	18.7	85.0	66.3	38.4
1937.....		28.6	23.3	20.1	28.7	20.1	63.0	59.8	41.3
1938.....	78.3	64.2	23.5	18.9	21.5	34.0	27.2	46.4	37.0
1939.....	46.8	43.6	32.8	20.0	24.7	28.1	33.2	52.1	35.5
1940.....	24.8	40.8	27.3	55.5	26.4	18.5	16.7	50.6	33.9
1941 (prov.).....				39.3	36.1	20.0	41.8	47.8	39.0

P.248, Sixty-second Annual Report of the
Department of Health, State of New York.

Thank you, gentlemen.

The CHAIRMAN: Thank you, Dr. Couture. Mr. Minister, have you any questions?

Hon. Mr. MACKENZIE: No.

The CHAIRMAN: Then we are ready for questions from the floor.

By Mr. Blanchette:

Q. I note here that the doctor refers to the book, "The Canadian Mother and Child". Incidentally, I wish to compliment the author of that book, which has received a very large circulation throughout our district. Would it be possible for the doctor to inform the committee just how many of these copies have been distributed to date, and whether those copies are more easily obtainable now than they have been during last year and the previous year?—A. We have distributed some 350,000 copies. We have experienced much difficulty in maintaining a supply, although budget provision has been generous because of unexpectedly large demand. The ratio of French and English was one-third French and two-thirds English. Consideration is presently being given to the printing of a fourth edition.

By Mr. Gershaw:

Q. May I ask the witness regarding maternal mortality? Our figures indicate all deaths from the very beginning of pregnancy. Are deaths in other countries, which have been compared to Canada, on the same basis? Also, has the witness any figures to show the relative mortality where the patient stays at home as compared with where the patient is in a hospital? Are these figures recent, and do they include cases where the sulpha drugs have been used, particularly in the care of puerperal sepsis?—A. They include all deaths. There is a little difference in the basis on which these data are published. There is a different definition on which we base these figures, but it does not account for much difference in so far as the maternal mortality is concerned. They are comparable for practical purposes.

The main difference lies in the definition of still birth which is different in different countries. In so far as the sulpha drugs are concerned, of course we have no report of when they have been used. We have no means of finding when these drugs are administered from a statistical point of view.

Q. What about hospital care?—A. You must take into consideration in considering hospital maternal mortality rates the fact that hospital deaths include a large proportion of emergencies. One cannot therefore draw any conclusions as to the advisability or inadvisability of hospital care for maternity.

The CHAIRMAN: Are there any other questions?

By Mr. Howden:

Q. I should like to ask Dr. Couture where the most crying need lies for care of pregnant mothers. Is it in the rural or urban centres? I think that is a very important matter to be brought out before this committee, because it is just possible we may not have the means to take care of this entire question. I think that part of the subject which presents the most crying need, as it were, should be kept before our minds.—A. I may not have made myself sufficiently clear, but I think I have stressed pretty much the need for care in the rural sections of the country.

Q. Hear, hear.—A. That is where we need it most urgently. Of course, the difficulty lies in sparse distribution of the population. Doctors are consequently in insufficient numbers to look after every mother. That is the main problem, the difficult one.

Q. May I follow that up with this question? In the event of our not being able to supply complete relief in this matter, what would be the minimum that would afford, shall I say, service along these lines? Would it be in the establishment of health centre depots or something of that kind, or what would you suggest?—A. We are looking for a solution of this problem. Each province has each a type of rural health service and they are all investigating and they are feeling their way as to just what is what in each locality in the advantages therefor. The answer to the question is not one that can be given at this time. In Manitoba they have a very successful project; municipal doctors are responsible both for the prevention of curative fields. These doctors attend to confinements. That might prove to be very satisfactory. Then we might consider the training of nurses in obstetrics in order to help the doctors. The nurses would help very materially, I think, to relieve the situation in the rural sections of the country.

The CHAIRMAN: Are there any other questions?

By Mr. McCann:

Q. I should like to compliment Dr. Couture on the excellence of the brief which he has submitted here today; and also to compliment him—and he will not take it to himself alone, because it goes to the profession generally—for

the progress which has been made over the years in the field of maternal and child hygiene. Now, the advantage of this brief, as has been the advantage of a number of briefs which have been submitted to this committee, is, in my opinion, that education, perhaps, is the most important factor with reference to this whole problem of maternal child hygiene. The second important thing which this and other briefs have demonstrated is that the profession has the knowledge to give to the public but they have been cramped entirely through lack of public funds. Those points to me stand out as the two most important factors which have been demonstrated in the several briefs which have been presented to this committee. Now, the reason that I make mention of these facts before the committee is this, that the committee is made up of the members of the House of Commons and when the estimates of the department of health come before the house in committee to be studied I would ask the members who are interested in public health and in social security to support the minister and to press upon the government the need of extra money for public health purposes and particularly for education as far as the federal department of health is concerned. Dr. Couture in his brief makes mention of the fact of how necessary it is that there should be a central agency that would have to do with public health education. Would he consider that under the health scheme which is to be set up at some future time that that work should be the particular function of the federal department rather than to depend upon the different provincial departments in disseminating whatever health propaganda they wish. My own opinion is, and has been for many years, that the federal health centre—although it has been argued that the matter of health is within the jurisdiction of the provinces—is desirable. If we desire to give any kind of health propaganda or give health statistics with reference to Canada that will be of benefit to our own people or that would be of benefit to other nations such as our sister dominions, that type of propaganda and those statistics and that type of education should come entirely from paid federal agents. I believe that is one of the things that is envisaged by the new Public Health Act, and I would ask for a greater scope for its influence. And I do want to press upon members of the house who are members of this committee that when the estimates come up the minister must have full support and that we must make an effort to convince the other members of the house who are not members or who are not as much interested as we are of the great need for public health education, and that the one deterring factor throughout the years has been the lack of public funds.

MR. VENIOT: Mr. Chairman, would Dr. Couture be good enough to give a brief outline of the reasons for the greater number of maternal mortality cases in Canada than in other countries, or the higher rate in Canada than in other countries with regard to mothers and children?

THE WITNESS: I do not think one answer would satisfy this question. There are a great many factors. An investigation has been made in Manitoba two or three years ago in order to find out the various factors. This pregnancy survey covered some 22,000 pregnancies; the facts have not yet been analysed, but I am sure we are going to obtain from that survey a wealth of information making us able to answer your question.

MR. VENIOT: Would you point out also briefly why it is safer to have babies in hospitals than in homes?

THE WITNESS: Well, having had some little experience I might be prejudiced in favour of the hospitals as most of my cases were hospital cases. Emergencies cannot always be foreseen. We have within reach in the hospital all facilities to cope with difficulties or unexpected complications. For instance, a transfusion may occur after a normal confinement and the need for this measure is not a matter of hours, it is a matter of minutes. For these reasons I am inclined to favour a hospital.

The CHAIRMAN: Dr. Puddicombe, would you care to comment on that question?

Dr. PUDDICOMBE: Mr. Chairman, what Dr. Couture has said is very true. Hospitalization renders facilities that home deliveries do not, and each case of obstetrics is an emergency—an emergency inasmuch as the child arrives at the time that it wishes and not at the time that the physician or the mother possibly desire, and it is not always possible to have adequate help present in the case of home deliveries. I do not think it is possible to hospitalize all the cases, but with a proper educational scheme and perhaps with less apathy on the part of the medical profession as far as maternal cases are concerned, I think we could improve our statistics. I think Dr. Couture is possibly a little bit harsh or a little hard on us about our statistics; that is probably done for emphasis.

Mr. McCANN: Mr. Chairman, I would like to add to the statements of Dr. Couture and Dr. Puddicombe and say that it is not a matter of choice, that this thing goes much deeper: it is a matter of facilities and economics, and the basic thing is the economics. The people have not got the money to pay for hospitalization, and if the conditions that we do hope to bring about under health insurance are such that these people will be cared for in institutions then the percentage of those who will avail themselves of the institutions will immediately go up and your mortality rate will go down. Men who practise in rural districts have got to make the best of facilities at hand; it is not a matter of choice with them in a great many instances, nor is it a matter of choice for the people that they cannot afford a better service; they have to put up with what they have.

The CHAIRMAN: I suppose, Dr. McCann, that is one of the reasons why you have asked the members to support the minister's request for an increased amount of money?

Mr. McCANN: Certainly.

Mr. WRIGHT: Mr. Chairman, I agree with what Dr. McCann has said; I think that this matter of the mortality rate in Canada has been largely due to economic conditions. I know that in the parts of Saskatchewan from which I come, in the northern district, it is not only a matter of education; you could give all the education you like to those people, but if they have not got the money wherewith to supply the needs, education is not enough in itself. I think that as far as we are concerned in the rural areas of Canada our trouble has largely been a matter of economics, and that is a condition which we in Canada, I think, can do much to change.

Mr. ADAMSON: I would like to support the remarks of Dr. McCann. Even in the city of Toronto we had a case quite recently where there was not a single bed in the obstetrical ward of a hospital for maternity cases. That was last week. Now, there is one question I would like to ask Dr. Couture: has he any statistics on infantile mortality in the first, second, third and fourth and subsequent pregnancies; in other words, do the later pregnancies, after the fourth and fifth, tend to show a higher infant mortality rate than the earlier ones, and, if so, are there any figures on that?

The WITNESS: Yes, we have figures on that, and it has been proven quite definitely that the first baby accounts for the highest cause of mortality. The mortality is lower for the third, fourth and fifth, then from the sixth birth on the rate of mortality rises again.

The CHAIRMAN: Have you any comments, Dr. Puddicombe?

Dr. PUDDICOMBE: Yes, I was under that impression. Dr. Couture says that the first pregnancy gives a higher mortality rate than any of the others. The second pregnancy shows a drop. The third, I believe, is perhaps the easiest child to have, and the fourth begins to get a little harder. After the fifth child the mortality rate increases. I think the greatest reason for infant mortality or

stillbirths in the first child is distortia or labour; but as you get to the fifth and sixth pregnancy haemorrhage rears its ugly head and toxemia is apt to appear because of lassitude or disinterest in the mother in her condition because she feels that she has been through the condition so often that she does not need the care she did have possibly with the first or second pregnancies.

MR. SLAGHT: I would like to ask Dr. Couture whether under the conditions there is any compulsion on hospitals who receive grants to maintain blood banks and have the blood available or is that left to the choice of those in charge of the hospital; has any consideration been given to putting some regulation into effect which will compel hospitals who receive public grants to maintain a reasonable reserve in their blood banks?

THE WITNESS: Well, the matter of keeping blood in the form we have it today is a recent institution. For this reason and because of the fact that all our supply is diverted for war purposes consideration has not as yet been given to establishing this regulation.

MR. HOWDEN: I am not going to ask a question, but I am going to make this statement because I think this is a good time to impress this matter upon this committee. I think all medical men will agree with me that there are emergencies that arise in childbirth which if met with in the home present absolutely a stone wall, in which even the most skilful medical man is helpless. I think that is something we ought to know, and I will be very glad to hear any comment on the matter from these gentlemen who are with us this morning.

THE CHAIRMAN: Dr. Puddicombe will you comment on that?

DR. PUDDICOMBE: The stone wall that Dr. Howden speaks of is that condition which comes up at the time of delivery—

MR. HOWDEN: Quite so.

DR. PUDDICOMBE: Such as severe hemorrhage—

MR. HOWDEN: Hydrocephalus.

DR. PUDDICOMBE: The condition of hydrocephalus is possibly not so much a stone wall because the woman may be transferred at that time for treatment, and the diagnosis of hydrocephalus is not a difficult one because distortia is evident.

MR. HOWDEN: I am talking of cases in the country where there is no hospital to be used and where there is no chance of getting to a hospital. There are parts of our western country, not only in Manitoba but all over the west, where there are no hospitals at hand, and if an obstetrician discovers a case of hydrocephalus or of contracted pelvis on his first call what can he do; what chance has he got?

DR. PUDDICOMBE: That of course, would require the attention of a highly trained obstetrician. Of course, these facilities are not always available, particularly in that part of the country that you speak of. I do not know the answer to that or what should be done in these circumstances. Certainly there are destructive operations on the child, and I imagine if the woman is left to herself the child will destroy itself; that is to say, her labour will destroy the child and there will be a still birth. The foetus will soften if the woman's strength holds out, and eventually either she or both will succumb; but the child, given sufficient strength from the mother, will eventually soften from this and be expelled even with a contracted pelvis. In marked cases of contraction, of course, a man would be very foolish to try to keep them in the home. If he had seen the case first, prenatally, he would probably be able to determine if there was the contraction.

MR. HOWDEN: A good many of these cases, unfortunately, are not seen prenatally.

Dr. PUDDICOMBE: That is the difficulty.

Mr. McCANN: Follow that up. That is exactly where the educational factor comes in.

Dr. PUDDICOMBE: Yes, and also, Dr. McCann, as you say, the economic situation. I realize that that is one of the big things in the whole situation. That mothers will not apply for the prenatal care, which they should, because it means expending more money for that, or at least they believe so. Actually I think a great many maternity cases are done now on a fee basis for the whole service. The number of calls they make to the physician are not considered, it is the case in general that is going to be paid for. If a man sees that case before delivery first, and delivers the child successfully, he may be paid \$25. If he sees it three or four times before he gets exactly the same amount.

Mr. SHAW: But it would mean extensive travelling on the part of the mother who lives 40 or 50 miles away from a town. I know that is the case in certain areas and it costs quite a lot of money to make regular trips to the town to visit the doctor; so, there is that additional cost.

Dr. PUDDICOMBE: That is very true; but if we had, as Dr. Couture said, public health nurses who could do blood pressure readings and who could do simple urinalysis, we could reduce the number of toxæmia cases very easily. It is not necessary for the physicians to do these things; it is a very simple procedure. We do them here in my clinic. My nurses examine the urine for me. I do not do these all the time; I take blood pressures; but I do believe nurses can be trained to do blood pressure readings, which would reduce the deaths from toxæmia if they were followed up and adequate treatment instituted.

The CHAIRMAN: Dr. Howden's question involves not only economic difficulties, but geographical difficulties and transportation difficulties.

Mrs. CASSELMAN: It also may be said to involve the care of the children in the home. Very frequently in the rural districts the mother cannot get in to the doctor because of the little children she leaves behind. The very fact she cannot get away may not depend on economics, but conditions in the home. It is not only a question of having the education, as some seem to think it is, it is a question of being in a position to follow the rules you have heard.

Mr. WOOD: Mr. Chairman, I sometimes feel this economic part of the rural section is overemphasized. Being a farmer myself I have been familiar with one or two cases where a good farmer prizes his live stock and does not find it uneconomic to send for the veterinarian to help the old mare deliver the foal or the valuable cow deliver the calf. I think the educational programme is a good thing, and I also think that we should put the value on the proper thing. I have often wondered sitting here, since we find it necessary to report deaths and register births, would it not be advisable after a limited time to report pregnancies to medical health officers and more or less make it compulsory to institute prenatal care. That is a suggestion that has come to my mind.

Dr. COUTURE: I might say I get a large number of letters from mothers who know; they are educated; but they have not got the services. So while we are stressing education we should at the same time see to providing the services.

Mr. DONNELLY: Dr. Couture, in distributing literature on the educational programme, how do you get in contact with the public? Do you get in contact with the public yourself or through the ministers of health in each of the provinces? Do you distribute your literature in each of the provinces and have the provinces distribute it to the public, or do you distribute it from here to the public yourselves? As far as we are concerned in western Canada I might say

that when I was practising medicine there we did not know there was such a department in Ottawa at all. We got in contact with the provincial ministers of health.

The CHAIRMAN: Since you have been sitting in this committee you have learned that there is such a department.

Mr. DONNELLY: Yes. Which do you do?

Dr. COUTURE: I am glad you brought that question up to the effect that you did not know about the existence of our services. We offer the medical officers of health of each of the provinces the publications and leave him the choice as to the mode of distribution. At the same time, I have always felt that we should keep a certain contact with the people through answering individual requests, thereby our services will be better known; but we leave it entirely in the hands of the provincial health authorities as to the mode of distribution they prefer.

The CHAIRMAN: Dr. Couture, the committee is very grateful to you, Dr. Puddicombe, Dr. Campbell, and Dr. MacHaffie, for the presentation. Before we leave this subject I should like to ask Dr. MacHaffie if he would like to add anything to the discussion.

Dr. MACHAFFIE: I have nothing to add.

The CHAIRMAN: Have you, Dr. Campbell?

Dr. CAMPBELL: No.

The CHAIRMAN: We have with us to-day representatives from the Canadian Federation of Agriculture, and I would ask Mr. Hannam to present the brief.

Mr. H. H. HANNAM, President, Canadian Federation of Agriculture, called:

The CHAIRMAN: Will you proceed, Mr. Hannam?

The WITNESS: Mr. Chairman, ladies and gentlemen, we very much appreciate the opportunity to appear before your committee. Perhaps I should say, however, that we were under a misconception in preparing our case; that is, we rather assumed that we might have half a session or more of your meeting in order to present the case. Now, I do not think that we have any illusions about our own importance at all, but we have been working for a long time on national health insurance in rural Canada. We printed a booklet and distributed it all over Canada; it has been studied in forums and groups and we have presented the case not only for farm people but for all the people of Canada. It is not presented from the standpoint of the farmers. We in our organization have an affiliated membership of 350,000. I say, "affiliated membership". If you took their families we have nearly 1,500,000 citizens in Canada; the other half of agriculture is not organized; therefore, we are attempting to present the case for nearly 3,000,000 of Canada's citizens.

I have rather a longer presentation here than I can manage to give you providing that your committee adjourns at 1 o'clock, and I doubt whether I should attempt to do it at all, either in fairness to your committee or in fairness to the farm people, in that time. If it is possible for us to have an hour then, I think we could manage. I know how valuable your time is. I know how many cases there are to present; and I appreciate the importance of the one we have already heard. The point is, is that agreeable, Mr. Chairman? I do think we would much rather return another time to present our case; a case of the size and scope we have to present cannot be dealt with adequately in half an hour.

Mr. WRIGHT: I would suggest that Mr. Hannam be given an opportunity to come back here and present his case at a later date when he will have adequate time in which to discuss it, because I know something of the nature of the material which he has in his brief. I know he wants an opportunity of discussing it and he represents a sufficiently large body of people in this country, that I think he should be given a better opportunity than is available to-day.

The CHAIRMAN: I was going to suggest that also, because he represents a very important group.

Mr. WRIGHT: I would like to ask before he starts in if what he has to present is a new plan of national health insurance; is it a plan different from the one that has been suggested by those who have made an intensive study over the last few years; or, is it comment on the plan as it has been submitted to the committee?

Mr. HANNAM: No.

Mr. WRIGHT: Is it an alternative plan?

Mr. HANNAM: It is a presentation of a complete plan that we are putting forward without any comments on any other.

Mr. WRIGHT: Or without relationship to the other?

Mr. HANNAM: Yes, and in some fundamental respects it differs from the other.

Mr. DONNELLY: Is that the same plan as the one with which we were circularized?

Mr. HANNAM: Do you mean the booklet on health on the march?

Mr. DONNELLY: Yes.

Mr. HANNAM: Yes. I think we have enough copies here of health on the march which sets forward the eight principles and gives the development of each one. And now, we can let you have these booklets to-day if you would care to have them.

Mr. McCANN: We practically all have them now.

Mr. SHAW: If, Mr. Chairman, it is not the intention of this committee to sit until half-past one could we arrange for a special meeting next week, or is your schedule at present complete?

The CHAIRMAN: The schedule has been drawn up for nearly two weeks in advance.

Mrs. CASSELMAN: Could we not adjourn now and come back at half-past one?

The CHAIRMAN: I am afraid not, Mrs. Casselman, on account of there being too many appointments. I would suggest that the statement of Mr. Hannam be placed on the record as it is and then we can study it and can come back after comparing it with the plans we have already discussed.

Mr. WOOD: There is one objection to which I might call your attention in that regard and that is this, that I have discovered so much in many of the plans that are devised in relation to even business and economics which contain a great deal which is not applicable to the farm situation, where you have other habits of living. And now then, as Mr. Hannam has said a large percentage of our farmers—there may be some things with respect to which Mr. Hannam might draw your attention that could be covered, some things which perhaps have some special relationship to agriculture. I know that he would not desire to draft a bill which would govern the whole of the population. It is much the same as the situation in which a farmer finds himself who is trying to locate a farm and very often his success or failure depends on that; as we all know, the farmer can pretty nearly always lose money and he generally does—nobody has ever explained how that is done. The same thing applies to many other things in our rural life. And I suggest, Mr. Chairman, that if Mr. Hannam was to present his brief without giving certain explanatory views on various phases of it it would probably lose a great deal of its value. Is that what you have in mind, Mr. Hannam?

Mr. HANNAM: Yes.

Mr. WOOD: Now, as a farmer, I think I can read that in Mr. Hannam's remarks.

Mr. HOWDEN: I move that the witness be heard. I think the matter will not receive the consideration due if it is held over.

The CHAIRMAN: There was another suggestion. The point I am suggesting is this, that Mr. Shaw at the last meeting, very wisely I thought, inquired as to whether or not it would be possible to get the briefs before the witnesses appeared. I know it is not always possible to do that; in fact, it is nearly always impossible to do it. Now then, Mr. Hannam is here with a statement; what is the objection to putting that statement on the record? We can read it and we can compare the differences with the other proposal and then when Mr. Hannam comes back he can give us his explanation and answer any questions that will be put to him. Is there any objection to that?

Mr. DONNELLY: I think the crux of the matter is this, we are all anxious to hear Mr. Hannam, to hear his side as compared with the other; and I think if we had his brief on the record that we would be in the position having read it, we would be in a better position to deal with it when he comes before us on another occasion to discuss it.

The CHAIRMAN: Yes, Dr. Donnelly; we have had the Marsh report before us for some weeks.

Mr. McCANN: We will have to have him back again anyway.

Mr. HOADLEY: May I ask, Mr. Chairman, is that the procedure with all of the other presentations?

The CHAIRMAN: Not with all, but as I was saying we had the Marsh report before us since our initial meeting and we have not even discussed it as yet. We have read it and no doubt most of us have given considerable study to it, and some day the author of that report will be called before this committee. He did not present it when it was put on the record.

Mr. GREGORY: My contention is that Mr. Hannam should be permitted right now to present and elaborate on this scheme. In that way we will have an opportunity of sizing it up, we will receive a certain amount of information today and we will have an opportunity in the meantime to consider what has been said in relation to what has not been said; and then Mr. Hannam should be invited back again to deal with the subject as he wishes on behalf of the organization which he represents; and I suggest that he should have an opportunity to do that at the earliest possible moment. There may be certain points in respect to which this plan differs from other plans which have been laid before this committee. I for one would like to see him have an adequate opportunity in which to make his presentation.

The CHAIRMAN: We all do. Mr. Hannam expressed the wish that he be given an hour in which to proceed continuously, in which to present his case. The way things stand it is impossible for him to do that to-day.

Mr. McCANN: Then Mr. Hannam does not want to break his presentation?

The CHAIRMAN: No, he does not.

Mr. McCANN: He would prefer to present it at one time.

Mr. HANNAM: Right.

Mr. McCANN: I would expect that. It appears that it will be physically impossible for him to present it to-day. Why not put the brief on the record and have another appointment to come back so that Mr. Hannam can then go into the details; I think that would be the only fair thing to do with respect to the organization on whose behalf he is making the presentation, and likewise the only fair thing to do in so far as the members of the committee are concerned who want to hear it.

The CHAIRMAN: Dr. McCann, there is apparently some objection to putting the brief on the record without Mr. Hannam being present when you hear it. He will have his brief with him for submission when he returns. I think that would be satisfactory to the committee.

Mr. HANNAM: My only point there, Mr. Chairman, is that we have already presented our plan in this booklet and we would like, if we have to come back later, we would like to put more time on our presentation; we have prepared it rather hurriedly during the last week under great pressure. We would prefer an opportunity of coming back later.

The CHAIRMAN: Mr. Hannam, you would prefer that?

Mr. HANNAM: Yes, I would, sir.

Mr. McCANN: Then I will ask Mr. Hannam this question: Would he desire when his brief is submitted that his pamphlet "Health on the March" be put on the record?

Mr. HANNAM: Quite.

Mr. McCANN: We could arrange quite easily to do that to-day. Most of the members of the committee have received that and some of us have read it. If it is put on the record and becomes a part of our official record it will probably be studied between now and the time when Mr. Hannam makes his presentation.

Mr. HANNAM: We are not making any important change in any of the principles that are published in that report. We have distributed nearly 20,000 copies, and those are not to individuals but to groups who have studied it. We went through it carefully at the annual meeting of the Canadian Federation of Agriculture in Calgary and it was endorsed unanimously. We have yet to find any press or any organization that has criticized it. We will be glad to put that on record as our report at the moment.

The CHAIRMAN: With the understanding that you come back with the statement you have here.

Mr. HANNAM: I will be glad to.

The CHAIRMAN: Probably extended and in more detail.

Mr. HANNAM: I will be very glad to do that.

Mr. McCANN: To bring the matter to a finality I move that Mr. Hannam be given the privilege and opportunity of putting on the record the brief which is contained in the pamphlet "Health on the March."

The CHAIRMAN: Will you add to that, that he be recalled?

Mr. McCANN: And that he be recalled at a time to be set by the Chairman.

The CHAIRMAN: You have heard the motion. All in favour?

Motion agreed to.

HEALTH ON THE MARCH

PRINCIPLES FOR A PLAN OF NATIONAL HEALTH INSURANCE*

Submitted by The Canadian Federation of Agriculture

PRINCIPLE NO. I

THE DOMINION GOVERNMENT SHOULD ENACT LEGISLATION FOR A NATIONAL HEALTH INSURANCE PLAN FOR CANADA

This legislation for National Health Insurance should be on the dominion statute books as soon as possible; because as will be seen by the points which follow, time must elapse before provincial action can take place.

- (a) *The large majority of the people are unable to pay for adequate medical care with its rapidly increasing scope and costs; while at the same time, those who give the services are not receiving a just remuneration. This state of affairs is having a serious effect on the welfare of our dominion.*

There has been a growing dissatisfaction in Canada for some time past concerning the inadequacy of public health and medical care services. (That phase of preventive medicine which is applied on an organized community basis is known as "public health"; the term "medical care" includes all those services provided for the care of the sick, i.e., medical, nursing, dental, hospital, etc.)

The depression exposed the needs of the people, and forced us to adopt medical relief as a palliative measure in many localities across Canada. On the heels of a decade of depression came the war.

Coincident with the outbreak of war, a factual study (1) was made available, by which, for the first time, the people were enabled to scrutinize the whole situation; and this study showed that on the basis of earning power, the large majority of Canadians are unable to meet the unpredictable costs of sickness; and that medical care and public health services are very unevenly distributed throughout Canada.

In the years 1941-42, the subject of health services became a project of increasing importance among the rural people, and continues to be so. Through the National Farm Radio forums they began to make a study of their local situation, and to become vocal concerning their needs—both from the standpoint of inability to pay, and also the poor distribution of services in rural areas. (2)

The costs of medical care of all kinds have increased tremendously during the past 25 years, as new methods of diagnosis and treatment have been discovered. But that this knowledge is not being applied is evidenced by our annual vital statistics, showing the large number of deaths from preventable causes. (1)

At the same time, many of those who are trained to give service are not receiving an adequate reward for their work; and moreover, this health personnel concentrates in the cities, because of greater opportunities and greater comfort; and also because better facilities are available—facilities which they have been trained to use and depend on in practice. Specialists naturally settle in cities, since it is only in the more populous communities that they can expect to earn a living. Consequently, the distribution of doctors, dentists and nurses is determined more by opportunities to gain a livelihood than by the actual needs of the people.

This serious lag between the knowledge of medical science and its practical application is having a detrimental effect on the progress of our dominion; and remedial action is long overdue.

* Principles presented to Dominion Government are in *italic* type.

- (b) *Health is a national problem which is becoming more and more evident under the stress of war conditions. The responsibility of the federal government in calling on man and woman power from all classes entails federal responsibility for the people's health.*

The centre of gravity of public opinion is swinging inevitably towards federal responsibility in taking leadership to solve the nation's health problem. The health study already referred to, showed a serious situation previous to the war. When war was declared, the problem became intensified, and new phases were revealed.

The calling up of men for war service showed a high percentage of rejections, varying in seriousness from province to province. For Canada as a whole, the rate was 44 per cent. This gave us a cross-section of Canadian youth (who should be in prime condition) and indicated that the general health situation must be even worse.

The public began to ask—"What about the rest of us? And what is being done on a national scale for those rejected?" The responsibility of the federal government in providing expert health services for enlisted men is recognized; but the provision of these services has resulted in a depletion of doctors, nurses, dentists and hospital equipment for civilian needs; and the dependents of enlisted men have no surplus to make provision for necessary medical care.

In war industries only, the federal government recognized the need for protection, to speed the war effort, by passing order in council 1550, to promote medical and surgical care and nutrition services for factory workers; but to what degree has this order in council actually been put into effect by industry? What about the dependents of those workers? And what about all Canadian workers and their dependents? Will there be the same obstacles to receiving care for returned men, such as occurred after the last war? . . . These are some of the questions being posed by an aroused public.

The increasing burden of taxation to finance the war will, as time goes on, decrease the ability of citizens to pay for health services, and make health insurance all the more imperative. There is no doubt of the people being in favour of national health insurance. As the situation becomes more chaotic, the people realize that if a national health scheme had been in operation years ago, the standard of health would be higher now; and the present breakdown of civilian health services could have been avoided; and they are asking, when Canadians of all classes are being regimented for the war effort by the national authority, why this same authority at the commencement of war, did not systematize the available health services for the home front.

- (c) *A national health plan would encourage a strong national sentiment. Confederation was intended to foster a national economy. There is now urgent need to revive this interest.*

The fathers of confederation, when they framed the British North America Act in 1867, could not possibly foresee our present situation. In section 91 of that act, authority was granted to the dominion parliament for a minor role in the health field—the census and statistics; quarantine for immigration and the establishment and maintenance of marine hospitals; Indians and lands reserved for the Indians. Soon after confederation, the provinces began to institute measures for the protection of their populations, and the dominion government confined its public health activities to a very limited field.

The discrepancy between the division of jurisdiction and the financial capacity of the provinces was not apparent at Confederation. "But the economic and social changes of the past seventy years . . . have made necessary state activities and state expenditures on health matters to an extent undreamed of by the Fathers. The mobility of modern society due to the speed and ease of travel;

the growth of urban and metropolitan communities; the interdependence for food and water supplies between widely separated geographical areas; the occupational diseases and physical hazards of high-speed, industrialized production; the loss of self-sufficiency of the family incident to the trend toward a wage-earning society; these and many other social changes have compelled governments at all levels to be concerned with the health of their citizens." (3)

This outmoded section of the B.N.A. Act must not be allowed to impede national progress. Never before was unity of purpose so vital for the preservation of the state. Health can be the strongest bond of unity, whether as between provinces, or as regards Canadian citizenship.

At a matter of fact, health so far as the individual Canadian citizen is concerned, is already the greatest common denominator we possess; for it is a fundamental human need at all levels of society. The thinking of the people is far ahead of that of their governments, or of any political party; because they recognize this problem as a basic national need, entirely removed from any artificial barriers. They are looking to the national government for leadership now, so that they can face the period of reconstruction after the war with a greater degree of confidence. This is the challenge which must be met.

- (d) *Regional planning must now be done with vision; and it is imperative that the federal government give leadership in this work. The whole country should be mapped out to show the proper distribution of hospitals, equipment and personnel needed to serve the population as a whole. Only in this way could adequate distribution of facilities for a national plan be accomplished.*

This regional planning must be done with the full realization of the task to be accomplished. This task in its fulness will be set forth in the National Health Insurance Act itself; and the federal government, in drafting this Act, will give the necessary legislative leadership.

The success in putting into effect the policies contained in the Act, will be assured by the degree of competence of the personnel of the central administrative health commission; and its provincial units. The central commission must have a national viewpoint, because there is urgent need to fill obvious gaps, to bring all provinces up to a Canadian standard.

For instance, the inequality in various fields such as public health protection, tuberculosis control, faulty distribution of health personnel and hospitals, as between provinces, and as between urban and rural areas in the provinces—these are only some of the problems to be faced and overcome by those entrusted with the regional planning which must take place, before national health insurance can function with equity and efficiency in the nine provinces.

PRINCIPLE NO. II

THE PLAN SHOULD BE ADMINISTERED UNDER THE DIRECTION OF AN INDEPENDENT COMMISSION AT OTTAWA

This commission should be composed of representatives of those giving and those receiving the services, the majority of representation to be lay people. Thus, finance, industry, labour, agriculture, welfare and others will assume their proper function.

When the federal government has taken the first step necessary—passing the National Health Insurance Act—they would set up an independent health insurance commission, with defined duties for the purpose of carrying out the Act. The personnel should be appointed because of their capacity to do the work indicated above—and on the basis of democratic representation of the various

groups concerned with the giving and receiving of the services of the plan. This power being delegated to an independent commission will obviate any thought of government interference, and satisfy those who object to working under state control.

PRINCIPLE No. III

THE LEGISLATION SHOULD PROVIDE THAT THE CENTRAL COMMISSION SHALL FUNCTION IN EACH PROVINCE THROUGH AN INDEPENDENT COMMISSION APPOINTED BY PROVINCIAL LEGISLATION, REPRESENTATION TO PREVAIL SIMILAR TO THAT OF THE CENTRAL COMMISSION.

This set-up would obviate any conflict of authority between the Dominion and the provinces.

The B.N.A. Act has always appeared to be an insurmountable obstacle to national health insurance; because under Section 91, the health of the people is the individual responsibility of each province. To surmount this constitutional barrier, each province would pass its own legislation and set up an independent commission, the vehicle through which the central commission would function. Thus each province without destroying its autonomy, would become a unit of the national health insurance plan.

It is obvious that the passing of federal and provincial legislation, the setting up of commissions for administration purposes, and the mapping out of the whole country, will take time; therefore, it is urgent that the Dominion government should pass the National Health Insurance Act as soon as possible, so that the necessary machinery can be prepared and ready to go into action.

PRINCIPLE No. IV

THE COST OF THE PLAN SHALL BE DEFRAYED FROM THE FEDERAL CONSOLIDATED REVENUE FUND

(a) *This is the most direct and economical system of providing the money. It would entail no extra work or cost of administration—the one yearly collection would suffice. This would be the people's contribution, collected through the customary channels.*

The federal consolidated revenue fund is the source from which all the necessary expenditures for the conduct of our national affairs are drawn. The Dominion has unlimited taxing power to obtain funds, which the provinces and municipalities do not possess. This money is secured through all manner of taxation, both direct and indirect. The channels are so numerous that they permeate every activity of our daily lives; so that all Canadians are contributing to it in some degree.

Even the man who has only the price of a cup of coffee, and makes this expenditure, is contributing to this fund; because the federal government controls and obtains revenue on all imports coming into the country. So that it can truly be said that this fund represents the wealth of the people of Canada. What more logical source from which to defray the cost of a national health plan for Canada.

Simplicity and directness must be our aim, in the financing of the plan. A national concept of health financing must appeal to us all, when we realize what it would do for national unity, and the lifting of the heavy burden the provinces are carrying.

Half of our troubles have been caused because we have tackled them with a provincial rather than with a national viewpoint. Here is the opportunity to approach the question of finance in the health field with a Canadian viewpoint—in keeping with the magnitude of the task to be accomplished. No extra machinery would have to be set up for the securing of the necessary funds for health insurance . . . the machinery is there, in constant operation.

- (b) *The report of the Royal Commission on Dominion-Provincial Relations accentuates the need for a central authority to obviate dangers of fluctuation of provincial income during depression periods.*

This report (usually referred to as the "Rowell-Sirois Report") shows us the urgent needs of the provinces prior to the war; and their inability to finance the necessary social and health services. It goes without saying that their situation is even more desperate, now that the war has made it necessary to invade provincial fields of taxation.

As we pointed out in section I-C, "the discrepancy between the division of jurisdiction and the financial capacity of the provinces was not apparent at confederation". But this discrepancy becomes more glaring as time goes on; and some method must be found of lifting the financial burden from the provinces. We have already shown how autonomy can be preserved in the administrative field. The tapping of the national revenue of Canada to the degree necessary to finance Canada's national plan for health, would give all the provinces the security needed, so that we can make a collective attack on the problem.

The need for a collective attack is clearly shown by the evidence brought forward by the various provinces, in their submissions to the Rowell-Sirois Commission. In brief, here is the picture:—

Costs of medical services are increasing, but the ability of their people to pay is not increasing.

The high incidence of preventable disease and death.

Inadequacies of hospital facilities, especially in rural areas.

Inadequate accommodation in mental hospitals.

The expenditures on behalf of the mentally diseased and mentally defective have increased more rapidly than the general population rate.

The problems of cancer, mental illness, venereal diseases and tuberculosis, which ignore provincial boundaries, can best be attacked by unity, rather than by nine more or less sporadic provincial attacks.

Early diagnostic and preventive measures are needed all down the line.

The urgent need for properly organized services in the field of maternal and child health.

The increase in the costs of dependency because of illness and premature death.

The crying need for federal responsibility and financial aid—in fact, some system of national health insurance—if the problem is to be solved.

They acknowledge their provincial lacks, but state that they are unable to finance the health services they should be giving to their people.

The following table shows the great need for financial assistance and a national viewpoint, if all Canadians are to have equal opportunity for health, regardless of provincial boundaries:—

EXPENDITURES BY PROVINCIAL GOVERNMENTS ON THE MAIN PREVENTIVE ASPECTS OF PUBLIC HEALTH: AND ALL GOVERNMENT HEALTH EXPENDITURES, 1936-37. (4)

Province	Preventive expenditures per capita	All health expenditures per capita
British Columbia.....	\$0 60	\$3 28
Alberta	0 25	2 22
Saskatchewan	0 23	2 01
Manitoba	0 23	2 20

EXPENDITURES BY PROVINCIAL GOVERNMENTS ON THE MAIN PREVENTIVE ASPECTS
OF PUBLIC HEALTH: AND ALL GOVERNMENT HEALTH EXPENDITURES,
1936-37.—*Conc.* (4)

Province	Preventive expenditures per capita	All health expenditures per capita
Ontario	\$0 19	\$1 63
Quebec	0 24	1 26
New Brunswick.....	0 27	0 76
Nova Scotia.....	0 16	0 85
Prince Edward Island.....	0 28	1 67
All provinces.....	\$0 24	\$1 68

It can be seen that public health expenditures on prevention in Canada do not approach the figure of \$2 to \$2.50 per capita, considered necessary by public health authorities for a full programme of prevention. The low average—24 cents per capita for prevention as compared with the average of \$1.68 for all health expenditures, reveals our vital needs. "An intensified programme of prevention should, over a period of time, materially reduce certain health expenditures, especially those on institutions for mental and tubercular patients, and to a lesser degree, those on general hospitals. It should be remembered, too, that without thorough-going prevention, there will continue to be a rising curve of capital expenditures on health institutions and hospitals." (4)

What would a well-organized campaign for prevention do for Canada? We can do no better than to quote from a portion of the British Columbia submission to the Rowell-Sirois Commission:—(This illustrates a possible saving for one province only).

"The money value of preventive work may be illustrated by referring the effects of deaths and disabilities from tuberculosis and the venereal diseases, both largely preventable, upon mothers' pension charges. In March, 1936, 16.1 per cent of all mothers' pensions cases could be attributed to tuberculosis or the venereal diseases. The annual cost of allowances for these cases was about \$93,000. From this it would appear that if the deaths and disabilities from tuberculosis and the venereal diseases were cut in half, over a period of five or ten years, it is quite possible that there would be an annual saving in mothers' pensions alone of about \$50,000—as much as the whole cost of the provincial venereal diseases programme during the fiscal year 1936-37. In addition, there would be other savings probably much larger in total, incidental to reduction of care for patients in mental hospitals, general hospitals, and other institutions, and to lessened demands for poor relief, care of dependent children, old age pensions, etc."

The lack of balance between provinces regarding important health activities is a challenge for federal action. We must not depend on the individual provinces to finance their own plans, or we will find ourselves perpetuating the present deplorable conditions. What has happened in the past will happen again. Even one year with the catastrophe of drought, grasshoppers or hail, could wreck the financial situation for the prairie provinces, so that they would be unable to function in the health field.

Even those provinces most highly industrialized are vulnerable to periods of depression. In fact, our internal economy is such that no breakdown can occur in any province without repercussions across Canada. Therefore, it is imperative that we rely on a fund which is stable, because it has unlimited powers and sources of revenue, which the provinces do not possess.

Such a huge area as Canada with such a small and scattered population, with such variable hazards of income—merits nothing less than a federal medium of financing to secure safety.

- (c) *This system of financing will mean equity so far as the individual citizen is concerned, in whatever province he happens to live; which could not be the case if there were nine methods of raising funds, with varying burdens of taxation to the individual citizen.*

Let us briefly review other methods of financing which have been advocated. The per capita basis we can dismiss, because it would inevitably penalize the man with dependents, and would not secure a just quota from wealth. Also, it would be very difficult to determine the "floor" of income below which it would be impossible to collect.

The contributory system, by which employee, employer, provincial and federal governments would pay a quota of varying degree. This system would make a levy on business, industry, finance and other sources of wealth, because automatically, they would make a contribution for every employee, besides their corporation and income taxes, etc. The individual wage-earner would pay only once; but the farmer would pay as both worker and owner. The "income earners" such as the countless small storekeepers, etc., with variable and unpredictable incomes, would present a problem, and compel endless adjustments; and again, with this system, it would be difficult to determine the floor below which people could not afford to make any contribution. The premiums of the individual contributors in each province would vary, because the cost for each of the nine schemes would vary; and there would be no equity so far as Canadian citizenship was concerned; and endless means tests would have to be made if a resident of a province moved to another, or from one employment to another.

It is impossible to anticipate the endless problems of adjustment, cost of collections and boards of appeal scattered all over the country. Instead of simplifying our present situation, we would be merely increasing our difficulties, and creating a heavy cost of overhead to be borne by the plan—or nine financial plans.

The financing of a national plan by a national method would eliminate all these difficulties, and place all Canadian citizens on a basis of equity.

PRINCIPLE NO. V

THE PLAN SHOULD INCLUDE ALL CITIZENS

- (a) *This is imperative because to adopt any other policy is to deny democracy and to destroy national unity. The Gallup Poll of the Canadian Institute of Public Opinion showed that 75 per cent of the people—men and women, rich and poor—were in favour of a national health plan.*

We are thinking of a plan, broad enough in its vision to enable the people as a whole to obtain full benefits from the marvellous achievements of medical science. Any other conception is not worthy of consideration by a democratic people. The dynamic of the national health programme should be the full participation of all the people in the programme.

At this period in the history of Canada (and of the world) when humanity is aroused to take part in the things which will produce the better life for all—it would be a calamity to lessen this enthusiasm of the people by using any methods which would destroy unity of purpose—any methods which would divide the people into separate groups.

Rather, we should use this aroused spirit of cooperation and move forward together in the march towards a higher standard of health for all Canadians. Health is moving rapidly from the field of thinking of a service or a charity for some, to be given by the better privileged to others—into the field of thinking of it as an integral part of the life of every Canadian. In other words, the people are thinking of health as a right of citizenship, of even greater importance than education or police protection, which are taken for granted.

At no other time in our history has this great opportunity arisen, and it must be faced with a proper feeling of responsibility. Legislation in the past has applied to particular groups or modes of living; but this which is contemplated embraces us all. The people have signified beyond question that they are for a national plan—the so-called wealthy were even more in favour than less well-to-do; the average in favour was 75 per cent.

- (b) *Complete coverage is necessary to achieve financial soundness and to spread the cost equitably. Any "ceiling" imposed on who shall be recipients of the benefits of the plan would cause endless confusion when there was a fluctuation of individual income.*

We must realize the situation which would have to be faced if only part of the population of Canada were included in a health insurance plan. On the basis of 1937 incomes, only 264,804 out of 11,120,000 people paid income tax on incomes over \$1,000 if single; or over \$2,000 if married. (5)

Even allowing for an increase of taxpayers since the war started, if we excluded those with incomes over a certain level, we would have a very small section of the population carrying a heavy burden—far heavier than if the cost were spread over all the people.

Justice demands the inclusion of all citizens, and in addition, this would simplify the administration of the whole programme.

One of the objects to be attained by Canada's Plan for Health is the setting free of all citizens from the financial worries of the past. If we used this plan to impose ceilings on who should be recipients, we would create a situation no better than in the past. We can imagine the bitterness which would accumulate if a man with a sudden decrease of income had to prove that he was below the "ceiling," and therefore eligible; or a man with an increase of income who found himself above the "ceiling" and therefore ineligible.

- (c) *Canada has an increase in both the diseases of later life and the proportion of older people. Therefore, if we are to plan for improvement in this situation a generation hence, we must encourage service to ALL the people; and there must be no penalizing of citizens with growing families. Also, it is obvious that unless all the population is in the plan, preventive health measures cannot operate effectively to serve and protect the whole community.*

This table shows the changes in upper age groups of our population. This problem varies in intensity from province to province—some having a larger percentage of old people than others. This has a bearing on the productivity of a province, and its future in the field of old age pensions. It is well known, for instance, that the maritimes have had a movement of young people to the States or other parts of Canada for some time past.

TABLE SHOWING CANADA'S AGEING OF POPULATION (6)

Year	Number 65 Years and Over per 1,000 of Population
1871.....	36.4
1911.....	46.6
1931.....	55.5
1941.....	65.1
1951.....	80.3
1961.....	90.8
1971.....	94.2

Immigration and emigration are not taken into account in this table; but neither is the effect of the ravages of war on our youthful population, which will be inevitable.

The rates for the degenerative diseases of later life (such as heart disease, cancer, nephritis and hardening of the arteries) are notably higher after 45 years of age. We are prolonging life, but not making it as productive or happy as it should be; and we are not taking measures to increase the number of producers in early life, and to cut down on the cost of dependency because of ill-health and premature death.

In fact, unless we take strong action under our health insurance plan, we will become a nation of increasing old-age pensioners and mother's allowance dependents; hospitals full of merely curative cases; with a decreasing youthful population, producing money to carry the top-heavy economy.

The great problem which confronts Canada is that of population. Our indifference to this in the past amounts to a policy of race suicide. In the past four years, our losses at the commencement of life (mothers, stillborn and those dying in the first year of life) exceed by 30,000 our losses in the last war. (7)

Our health plan must make a concerted attack on this human wastage; it must raise the standard of care of the group with large families; and liberate the group who should be having and raising children, but who have been most penalized by the cost.

Quite aside from all this, a campaign for the protection of the family would be impossible to carry out, if some in the community were included, and some excluded from the plan; and the improved system of health recording which we anticipate, depends on all being part of the plan, and imbued with equal enthusiasm to see that it is a success.

PRINCIPLE No. VI

THE PLAN SHALL INCLUDE ALL SERVICES NECESSARY FOR THE PROMOTION OF POSITIVE HEALTH, AND THE PREVENTION AND CURING OF DISEASE

It is needless at this stage to enlarge on what shall comprise these services. If those who are responsible for the outlining of Canada's programme for health, approach the problem with the proper conception, there will be no withholding of anything in the field of science—preventive, diagnostic or therapeutic—which shall be needed for the provision of these services. What has been available to the few in the past must be given freely to all.

When section I-D of these principles is fulfilled, before launching health insurance, with the financial backing of nothing less than the wealth of the people of Canada, there will be no reservations whatever in the services to be obtained by every Canadian citizen, in whatever part of Canada he may be.

PRINCIPLE No. VII

THE PROMOTION OF POSITIVE HEALTH AND THE PREVENTION OF DISEASE SHALL BE THE PRIMARY PURPOSE OF THE PLAN

- (a) *This two-fold purpose must be integrated with the practice of medicine, and not considered as at present—merely a subsidiary under public health. Although the need for curative measures is fully recognized, we have not begun to realize the possibilities for improvement when all the community is organized in a health programme. Our planning must be with this end in view.*

“Preventive medicine is that part of medicine which is primarily interested in disease prevention and health promotion. That phase of preventive medicine which is applied on an organized community basis is known as public health. Because public health is the legal responsibility of some official health depart-

ment, the general practitioners of medicine are apt to think of all preventive medicine as something in which they may have an interest, but in the practice of which they have no responsibility." (8)

When we examine our vital statistics over the past 25 years, we can see that the greatest advances have been made in the field of communicable disease—by inoculation, sanitary inspection, and control of milk and water supplies, etc. This is the job of our public health departments, financed through taxation, and working on a community basis. Where sufficient budgets are provided, and the programme continues without cessation, constant improvement takes place.

The fact remains that health teaching and prevention of disease have been left to the public health field. Financially, it has been to the interest of these departments to prevent disease. But under our present system of monetary reward, it has been to the financial advantage of the private practitioner to look after sickness. This is inevitable, because the majority of people do not go to doctors, unless they have diagnosed themselves as being sick enough to seek his services; in other words, they hesitate to pay fees to find out if they are "well." This was forcibly drawn to our attention by the fact that in the course of over 200 meetings among Ontario people, with an average of 50 at a meeting, the question was asked, "How many of you go to your family doctor for an annual check-up?" In every fourth meeting, on the average, one hand was raised!

The two, therefore—public health and private practice—have been at variance to a great degree. The need for curative medicine will always exist; but unless we wish to see our health plan overwhelmed by the burden of curative medicine in all its aspects, it must be strongly organized on the basis of positive health and disease prevention being brought into the field of the general practitioner.

(b) This entails a better method of statistical recording than exists at present; the object being that the health progress of any part of the country can be detected at a glance. This would be complementary to the present movement for better vital statistics—both mortality and morbidity.

If we are to enlist the vigorous and informed cooperation of the public, we must have a more localized statistical picture than exists at present. These records should show morbidity (sickness) figures, as well as mortality (death) figures.

An attempt can be made to discover rural rates, by deleting those of places of 1,000 population and over. But we are told that this is not an exact computation, because so many rural births and deaths occur in city hospitals. So we are confronted with a problem. Toronto, for instance, has lower maternal and infant death rates if "residents only" are given; and there is no reallocation of the cases which come from outside.

Therefore, a large proportion of our population has no way of knowing what their situation is, or what standards to work for; because statistics are by place of occurrence and not by place of residence.

It is impossible to gauge the degree of sickness and death among the people, merely by the occupancy of hospital beds in the larger centres. What about the thousands who occupy beds at home, of whom there are no records?

The report of the health inspection of school children is almost entirely confined to urban centres. This gives us a picture of the degree of sickness and defect among a section of the population; but it is an unknown quantity for the rural areas. Where they do exist, they show the large percentage of defects, both medical and dental, which are discovered but not corrected; and how many leave the eighth grade still carrying this burden with them.

Oxford county in Ontario is the only one which has made a complete medical inspection of its rural school children. In 1940, out of over 2,614 children given complete physical examinations, 983 were found with over 1,100 defects. The following year, only 141 of these defects had been corrected; and 828 children were discovered with new defects.

This drove home to the rural communities of that county the great need for prevention as well as some system of correcting defects when discovered. If we multiply the experience of only one county in Canada, we get some idea of how terrific the total problem is—and why such a large percentage of our young men were rejected for war service.

There is a lapse of two years before the figures for the dominion and the provinces can be made available to the public; and of a year in the case of cities. It is a tremendous undertaking; but when compiled, a sufficient regional breakdown is not available. If the people are to work intelligently towards better community health conditions, they must be able to see the picture locally, as it applies to them; and if the various commissions—federal and provincial—are to be able to see the progress under national health insurance, the present records are not sufficient.

In the past, surveys have been conducted intermittently, in various parts of the country, to discover the degree of care which certain groups are getting, and the causes for certain high death rates. We should have our national plan so well organized that a continuous picture will be available, and remedial action taken where it is necessary.

- (c) *The family must be taken as one complete unit, so far as their healthy environment, proper nutrition and health guidance is concerned—and not as at present, where the father may consult one doctor, the mother another, and the health of the children and the welfare of the family as a whole be left to chance.*

The principle laid down at the commencement of this section must be utilized for the protection of the family, as the first unit of society, and the one of which all communities are composed.

Much is being said of the preservation of the family doctor relationship. Unfortunately under present economic and distribution conditions, this does not exist for thousands of families. Under our health plan, we will make it a reality.

Also, the higher up the economic scale we scrutinize the situation, the more we see that the various members of a family are delegated to innumerable specialties; and we are rapidly losing the picture of the family as the unit and the aim of medical practice.

The inter-relationship of the various members of a family has great significance on the well-being of the family as a whole—mentally, physically and socially. Moreover, the individual must be considered as having the disease—and not the disease which is in the individual.

The doctor, then, must be in the position of having for his primary purpose that of keeping the family well. There are many factors which contribute to a condition of well-being, both mental and physical. A healthy environment means not only a home which is sanitary and roomy enough for the needs of the family; it also means proper relaxation and recreation. Food is not merely for satisfaction of hunger, it means a balance which will maintain growth and preserve resistance to disease. Health guidance also means teaching the family how to live.

Where these conditions for the preservation of the family do not exist, the doctors of the future must be in the position of leaders in reform for the rights of humanity. They must champion those things which assure health to the individual and all members of the family.

- (d) *We visualize the general practitioner as the very foundation of the success of the plan. On his shoulders rests the promotion of positive health and the drastic curtailment of the diseases and abuses under which the people at present labour. The general practitioner must be strategically placed*

and well remunerated; and all services necessary for the success of his important work must be easily available. It is because the general practitioner in the past has been frustrated by the economic set-up that the people have suffered needlessly, and that there has not been the advance in national health, paralleling that of science. The growing population of our mental institutions and the sick in our hospitals (the majority of whom should not be there) is an indictment of our present situation. Therefore, the plan must be so organized that the general practitioners can "go all out" on a co-ordinated, militant campaign for health. This will mean an entire change in the attitude of our medical schools, the education of all health personnel, and the proper integration of research into the plan. We believe that this will be to the advantage of both those giving and and those receiving the services.

The great hope for the future lies in the general practitioner. We see that he must be restored to his proper place in the scheme of things.

The mapping out of the country according to the needs of the people will reveal the great need for decentralization of health personnel. For instance, in Quebec province, 2,600 of the 3,000 doctors are established in the cities and towns, leaving only 400 to serve the rural areas. Over 40 per cent of the population of Quebec live in rural areas, so it follows that 13 per cent of the doctors have to divide their services among 40 per cent of the people of the province. More than 1,200 municipalities, parishes, or rural communities have no doctor, and the same situation exists in other provinces. (9)

In Ontario, 41 per cent of the people live in areas of less 1,000 population; but only 25 per cent of the doctors are situated in these areas. (10) Many of the townships have no doctor. Truly, it is something almost inconceivable in a civilized country.

Before this needed decentralization of all health personnel can take place, community health centres must be set up wherever needed, properly equipped with diagnostic and therapeutic facilities. These need not be elaborate in construction; but perhaps similar to the municipal and union hospitals in the West. This would cut down the high cost of overhead which burdens the individual worker at present; and enable the health personnel in all parts of Canada to keep abreast of scientific advances in their daily practice. All necessary services such as X-ray, laboratory, dental, nursing and specialist should be co-ordinated in these centres.

The present method of individual practice is the most expensive imaginable, and has been a large contributory factor to the high cost of medical care. Instead of ten doctors and ten dentists with twenty expensively equipped offices, we will have a more co-operative use of facilities, which will cut down the cost of overhead tremendously; also, the more general use of facilities will lower their cost.

There will be no limit to the development and expansion of these health centres. They must be planned with a long-term view. We use the term "health centres" advisedly; for we do not visualize them as hospitals in the accepted sense of the word, with an increasing number of beds. Rather, we visualize them as centres to keep people out of hospitals; and to promote preventive medicine and education along health lines.

This would include practical demonstration in the fields of nutrition and maternal and child care as the very foundation of the health of the family. Research would have unlimited opportunity for the integration of its work into the daily practice emanating from these centres. When discoveries were made, they could be applied simultaneously all over Canada. These centres would also be invaluable for research workers themselves in the medical and sociological fields.

Local schools would have a source to tap in teaching children what it actually means to be democratic, active participants in a plan for health. In fact, we can see new vistas opening up as health and education will become true partners.

The statistical records should be on exhibition, to show the people and the health workers the progress being made . . . cutting down of absenteeism in schools and industries, and the improvement at all levels—pre-natal, pre-school, the school years, and so on—so that there is a complete follow-through.

In fact, these centres will be manifold in purpose. Besides providing hospital beds in the area, and the point from which the work of doctors, nurses and dentists will radiate, they will be centres of education and inspiration for the people, and the mediums for more rapid and localized statistics to show the progress under health insurance. In this, the press, the film and the radio will play an important part.

So we see that bringing health services to the people is not the only factor to be considered. The fact that the people will feel and know that it is their health centre will be the underlying principle of the whole set-up. The health consciousness of the people will be enlisted, to work towards a better standard of life for all.

For the purpose of clarity, we have spoken of "those who give and those who receive" health services. The truth of the matter is, that there must be full cooperation between the two, if national health insurance is to be the means to the end which we hope for Canada. It is too big a job for the health workers without the help of the people.

And what of the teaching of those who work in the field of health? Leaders of medical education are emphasizing the need for a change in the curriculum if medical students are to keep pace with the growing demand for health rather than the treatment of disease. The following excerpts show us the opinion of an eminent Canadian on the subject. (11):

"In no field of activity is the saying 'the study of mankind is man' more applicable than in the practice of medicine. If the study of man is an essential for the doctor, and if the doctor treats the patient and not the disease, is our present system of medical education the best that can be devised to fulfill this purpose? In the clinical years, the student is unquestionably brought into intimate contact with man when he is sick, and he has many opportunities to learn a great deal about him when he has been affected by some disease; but the question may be asked, 'When does he receive instruction on man when he is not sick; or, in other words, when he is healthy?' "

"Does the student learn to examine a person-as-a-whole, and determine whether or not he is healthy in mind and body? Has the student been made to realize that health is something more than the absence of disease; that it is a state in which a person lives and enjoys life, just as certainly as a state of disease is one from which he may suffer and die?"

"An unqualified affirmative answer cannot be given to any of these questions. The reason for this is not difficult to discover. In my opinion, it is to be found in the standpoint from which medical education has been approached. Health as a positive state of the human being has not been recognized as an objective in medical education and in consequence, no concrete instruction has been given in it."

The writer suggests that a new name should be given to the university course, which would convey to students the comprehensive nature of this new objective . . . a name such as "human science." Even if such a name only impresses the student with the wider outlook and change in point of view of the course, a useful purpose will be served.

An American doctor shows us the importance of the general practitioner of the future in these words (12): "Your general practitioner will develop his diagnostic skill, his ability to make early diagnosis. He will develop his technique in preventive medicine. . . . He must keep abreast of medical progress. . . . He himself will do about 85 per cent of the medical work in his practice. . . . He will be the clearing house for all special attention to his patients."

To this we would add that our health personnel should be trained in their courses to study the family as the unit they will serve; and we foresee that under the set-up for a health plan which we have indicated, in the future doctors, dentists, nurses and others will have ample opportunity for this at the health centres; instead of being largely confined to class rooms and hospitals, with sick individuals as their sole source of study and inspiration.

PRINCIPLE No. VIII

WE BELIEVE THAT COMMUNITY EFFORT MUST HAVE A PLACE IN THE PLAN

Since municipal health services in many western municipalities have proven an ideal system for the practice of preventive medicine—in raising the standard of community health, radically lowering sickness and death rates, and decreasing the need for hospitalization—every opportunity should be given within the national plan for the preservation and enlargement of this method of providing services locally. Maximum efficiency and practicability should be sought, through local democratic participation of the people served. The dynamic of the rural community must be utilized in a programme for better health.

In order to give a clear understanding as to the purpose of the Federation of Agriculture in helping to further health services on a municipal basis, it is only right that we should clarify the situation at this point.

It is recognized that public health cannot operate efficiently unless communities are served by full-time health officers. In the past two years, those who have been working amongst the rural people of Ontario have had ample opportunity to note the growing dissatisfaction with the inadequate service provided by a part-time medical health officer. He is paid a retaining fee from \$50 upwards; and the service he gives varies from an occasional visit to the schools with no inspection of the children—to a considerable amount of inspection and immunization. Unfortunately, the former seems to prevail in the majority of cases.

Under a health insurance plan, the ideal would be to have every centre or unit served by full-time public health officials. It is obvious, however, that there are not enough trained in this field to serve the whole country. The municipal doctor system, as operating in Saskatchewan and Manitoba, automatically accomplishes the results desired by public health experts; as in those areas, every doctor becomes medical officer of health; and public health and the practice of medicine being brought together under the charge of one man, has proved that both activities benefit.

This is logical, because he is more interested in preventive medicine from the aspect of public health; and the more public health work he does, the less sickness he has in his daily practice.

Dr. Davison, Deputy Minister of Health for Saskatchewan, points out: "It is an ideal system for the practice of preventive medicine" . . . and "If the whole profession in Saskatchewan had immunized, during 1935, as thoroughly in their practices as had the municipal doctors in their districts, approximately three times as many persons would have been immunized against diphtheria, smallpox and scarlet fever as actually were immunized."

A two-year survey of the work of the municipal doctors in Manitoba was made from May, 1938, to April, 1940, through the generosity of the International Health Division of the Rockefeller Foundation, and with the assistance provided by organized medicine in Manitoba. The results were outstanding. Briefly, they were as follows:—

The maternal mortality rate was nil, as compared with the provincial rate of 4.3 per 1,000 live births.

The infant death rate was almost 14 points lower than the provincial rate—40.2 as against 54 per 1,000 live births.

The “disability” or sickness rate was only $\frac{2}{3}$ of the accepted rate for Canada.

The hospitalization rate was only one-third of the provincial rate.

Doctors reported three times more people were seeing them in their offices than they had to attend in their beds at home—in other words, they were nipping serious illness in the bud.

The cost of this work was only 44 per cent of the cost of work done by doctors in a municipality where the system of fees prevailed.

The wonderful results obtained are out of all proportion to the comparatively small amount expended. These results depended on the way the work was organized, and on the inescapable fact that it was to the financial advantage of the doctors to keep people well, as they received no more if they were ill!

Dr. Jackson, Deputy Minister of Health for Manitoba (13) gives data to show that these doctors in their municipalities were giving a high type of medical service to their patients; and the value of the statistics revealed by the survey.

The movement of Ontario farm people to adopt this method of securing health services was no flash in the pan; but the result of much study and discussion through their farm radio forums and other mediums. As the war has progressed, they have been hard hit by the depletion of doctors in rural areas; and the available doctors in towns showed an increasing unwillingness or inability to go out to rural areas. The additional expense involved in this was another factor.

Since the Ontario Federation of Agriculture sponsored the delegation to Premier Hepburn a year ago (14), asking for the enabling legislation which would permit farm people to vote locally so that they could use municipal funds for health services—the situation has not improved.

The Canadian Medical Procurement and Assignment Board recognized the effects of the war on rural areas when they pointed out that rural doctors have joined up for war service out of all proportion to those in urban centres. They issued instructions concerning the rationing of doctors as an emergency measure—that the available doctors in rural areas should work in “zones” to obviate overlapping of services, and to help the gas and tire shortage. It was shown that the services of doctors would have to be assured to the people by their actual transfer and subsidization on a salary basis, where necessity existed. The Ontario Medical Association indicated in a recent bulletin that their objection to this type of work would be largely obviated if a community assured the doctor a “net” income.

The Ontario Federation of Agriculture endorsed the action of the people, realizing that not only were they offering a solution to their problem which had been aggravated by the war; but also that the awakening of the people to undertake a co-operative, democratic community effort was the most hopeful sign to date; and that any units so set up would be educating the people to be active participants in the health field; and in no way be detrimental to any larger movement such as health insurance. Rather they could be integrated with ease, and prove a valuable contribution, because they would provide local statistics which are lacking at present.

Municipal areas in the west, which have been working with their key man—their community doctor—have made an invaluable contribution. To the sound foundation which they commenced with, they have added hospital, surgical and other services in many cases. Under health insurance, the services of these areas would be augmented and the incomes of the doctors increased, commensurate with the important work they are doing.

The enthusiasm of farm people, their eagerness to become active participants in community health, is the very underlying principle which we feel should be the dynamic of a national plan. All workers in the health field, and governments at all levels, should welcome this awakening of the people to their own duties and responsibilities. If they do not, then democracy is being denied expression at the source.

We believe in these broad principles for national health planning; and we realize that details cannot be worked out until all committees meet and pool their views. Therefore, we anticipate this opportunity being given to all representatives of those who would be giving and receiving services under the Plan.

PART II

HEALTH INSURANCE IN OTHER COUNTRIES OF THE WORLD

Health insurance is not new. Germany was the first to institute it, in 1883. Twenty-eight European countries have some form of health insurance—likewise, Chile, Argentina, Brazil, Uruguay, Palestine, Australia, Japan and New Zealand. The Union of South Africa has drawn up a scheme which is not in effect.

All systems adopted since the last war have contained compulsory features. In the case of Denmark, Italy and Switzerland, both compulsory and voluntary systems prevail, applying to different fractions of the population. The scope of the medical services provided by insurance varies widely in different countries. No insurance scheme provides complete medical care of all forms, although the medical benefits are very comprehensive in some. European systems are commonly “poor-man’s systems,” and do not embrace entire populations. The war, of course, has disorganized health insurance in Europe; but we see that advances had been made.

Great Britain

In 1912, Great Britain passed an act for compulsory contributory health insurance, generally known as “the panel system.” The act covers manual workers of 16 years of age or over, employed under a contract of service, and non-manual workers earning less than £250 a year. Previous to the war, some 18 million workers were included in the scheme.

The weakness of the plan is that dependents are not covered by the benefits, only the worker himself or herself. Nor is there any provision for the small independent worker. Specialist, hospitalization, dentistry, glasses, etc., are not included; doctors are apt to have too many patients on their panels, and give more attention to paying patients. There are apt to be abuses of the sickness benefit; and it is felt that it should be quite separate from the insurance benefit.

New Zealand

In the case of New Zealand, health insurance is a part of their Social Security Act of 1939, which provides for a system of medical and hospital benefits, as well as for old age, widows’ and other pensions. Benefits include services of a general practitioner; medicines, drugs and approved appliances;

hospitalization; full maternity care; and sickness benefits when the worker is unemployed because of illness. Additional benefits contemplated but not yet provided for, are specialist and consultant, radiological, dentist, home nursing and domestic assistance when the mother is ill.

Owing to considerable opposition on the part of the medical profession, several amendments have been made regarding the part of the general practitioner in the scheme. The rate of contribution cannot be compared with any purely medical service, since it covers the various types of pensions and unemployment benefits as well. The registration fee is 5s a quarter for all men over 20 years of age; for all others 5s a year; and a tax on all salaries, wages and other income of 1d for every 1s 8d, or 5 per cent of the total income. These contributions go to the Social Security Fund.

The results of New Zealand's plan for Social Security are already showing a great increase in the birth rate. For instance, when the Labour Government came into office, the birth rate was at its lowest level, 16·17 per 1,000 of population. In 1936, it rose to 16·64. 1937 saw a further rise to 17·29; 1938 to 17·93; 1939 to 18·73. After the maternity benefit was introduced in 1940, it rose to 21·19; and 1941 to 22·81.

The story told by these figures is a tribute to the Labour government, in a period in which the birth rate is still declining in most countries of the world. There has also been a decline of absenteeism in industry, due to illness; and an increased rate of production.

This is a lesson to us. Here we are, with the heritage of one half of a continent, and a totally inadequate population to develop it. You would think that we would have come to our senses long ago, and developed our human resources to the utmost.

The Soviet Union

When we look at Russia, we find that their system for health is not merely a part of their whole system of social insurance—it is part of their daily lives. They are doing things for themselves which other countries have not even begun to consider. Their achievements are all the more remarkable when we realize that they started from scratch. From a condition of revolution, famine and disease; utter poverty; with 90 per cent of their people unable to read or write, they sprang from the age of candle-light, skipped the gas-light age, and emerged into the electrical age in a few years. What has been accomplished since 1922 is almost unbelievable to us, who are accustomed to the slow process of evolution of capitalist states.

When they faced their problem of health, as well as all their other problems, they realized that nothing short of heroic measures could make up for the neglect of the past, and enable them to catch up with other countries. Where seven million children are born every year—the equivalent of the total population of many countries!—nothing short of the whole power of the state would suffice to guard their health and development. Nobody reading about Russia can fail to see that everything they have done is directed towards the protection of mothers and children. In this regard, not only have they caught up with other countries—they have outstripped them all.

"It seems to me that the following four points represent the most characteristic features of the Soviet health system. 1. Medical service is free and therefore available to all. 2. The prevention of disease is in the foreground of all health activities. 3. All health activities are directed by central bodies, the People's Commissariats of Health, with the result that 4. Health can be planned on a large scale."

"There can be no doubt that the Soviet system of social insurance is infinitely superior to any insurance system in capitalist countries. The costs are what they should be, part of the cost of production. The benefits are infinitely

greater than under any other insurance scheme. The worker is guaranteed complete medical service, he is given social security. He is entitled to it because, after all, he is creating the values that make such a scheme possible."

"The general idea is to supervise the human being medically, in a discreet and unobtrusive way, from the moment of conception to the moment of death. Medical workers and medical institutions are placed wherever anyone, in the course of his life, is exposed to dangers. Medical supervision begins with the pregnant woman and the woman in childbirth, proceeds to the infant, the pre-school and school child, the adolescent, and finally the man and woman at work."

"As soon as a woman becomes pregnant she is examined in a special section of the Women's Consultation Bureau, and is given a certificate which entitles her to many privileges. She is given regular instruction and care at the bureau, and is further advised by a home visitor who inspects conditions there. If she is employed, she is granted an allowance for procuring necessary articles of infant care. Special allowances are also granted to mothers of large families. All workers are granted 56 days of leave prior to and 56 days after childbirth on full pay. In cities practically 100 per cent of all women are delivered in hospitals under the best medical conditions. In rural sections small maternity homes of five or six beds are being rapidly provided for every collective farm. As a result of the vast increase in the number of maternity homes and nurseries, infant mortality has been considerably reduced."

"The Commissariats of Health are not alone in their fight against disease, in their endeavour to keep the individuals socially adjusted or to readjust them as the case may be. The trade unions seeking to improve the working and living conditions of the population, the Council of Physical Culture endeavouring to develop a strong and healthy generation, the Commissariats of Education preparing the people to accept scientific medicine—all these agencies work in the same direction, and are powerful allies of the medical corps."

"The state has but one purpose to promote the welfare of the people, of all the people, without distinction to raise the material and cultural standard of the population; to liberate man from the bonds of poverty, of ignorance and disease. This and only this justifies the existence of the state. In such a state, the health programme is one part of the great programme of the nation."

"As early as 1920, more than 60 per cent of the total appropriation of the Commissariat of Health was spent on the prevention of disease. It would be very difficult to figure out exactly how much money is spent on prevention to-day, and how much on cure, because the distinction has disappeared. Every medical worker, wherever he may be situated, is working toward the goal of the prevention of disease."

"Soviet medicine accomplished one of its most brilliant achievements in opening up the health resorts of the country and making them available to the working population. An increasing number of workers go on extensive excursions every year. . . . In the summer months, millions of people are on the road. . . . This is not only a recreational but an educational activity as well."

"Russia was the first country to organize rest and recreation in a national way and on a large scale. . . . The Soviet worker has the shortest working day and therefore the greatest amount of leisure. . . . Every factory has its club to enable the worker to use his free time in such a way that it will benefit his physical and mental health, allow him to develop culturally and lead an enjoyable life." (15)

Can we wonder at the terrific drive of the Russian people? They know what way of life they are fighting to preserve; and it is their ability in having built this way of life in 20 years which is the great contributing factor to their morale.

Situation in the United States

In 1928, a committee of 50 experts in the health field commenced a five-year programme of fact-finding. The result of their labours was "The Costs of Medical Care" in 1933, in 28 volumes, covering every aspect of the problem. The situation revealed was very similar to that shown by the "Study of the Distribution of Medical Care and Public Health Services in Canada", making allowances for differences in administration and population.

In 1937, the President's Interdepartmental Committee to Coordinate Health and Welfare Activities, charged the Technical Committee on Medical Care to survey the health and medical care work of the United States government.

As the study progressed, two facts became increasingly clear to the technical committee; first, that existing services for the conservation of national health were inadequate to secure to the citizens of the United States such health of body and mind as they should have; second, that nothing less than a national comprehensive health programme could lay the basis for action adequate to the nation's need.

In March, 1938, the President invited representatives of the interested public and the medical and other professions to examine the health problems in all their major aspects and to discuss ways and means of dealing with these problems. On July 18, 19 and 20, representatives from all walks of life attended the conference at Washington—medicine, surgery, mental hygiene, public health, pediatrics, public welfare, social work, industrial hygiene, parent-teaching associations, veterans' organization, labour, agriculture, engineering, nursing, dentistry, osteopathy, hospital administration, pharmacy, fraternal organizations, big business, radio broadcasting, education, etc. Most of these spoke on behalf of the people they represented.

The findings of the Committee—that one-third of the nation was ill-housed, ill-fed, ill-clothed and not receiving adequate medical care—led to their recommendation that \$850 million a year should be spent on an extension of public health, hospitals, and maternal and child care services over a ten year period. They also recommended health insurance for all the people, estimated to cost about \$2,600,000,000 a year for 130 million people—to be furnished at the rate of \$20 per head per annum. This figure excluded services already provided through tax funds, took account of reasonable economies which could be made, and excluded certain current wasteful, valueless or even harmful expenditures. As we know neither plan has been carried out.

The American Medical Association approved the whole programme of the committee except the proposal for health insurance.

"Voluntary hospital insurance has developed rapidly in the United States during recent years. More than 70 hospital insurance schemes are now in operation and, in general, each project is organized on a non-profit basis with annual dues from ten to twelve dollars, with a guarantee of three weeks' semi-private hospital care per year. Medical fees are not included, but usually special rates are given for extra services. The plans vary greatly in detail, but the same general principle holds of insuring against hospital costs through the payment of a monthly premium. The insurance is usually restricted to groups for obvious reasons, but may include families."

"The American Medical Association has opposed any form of compulsory insurance or indeed of any plan that is not controlled entirely by the medical profession. Local medical societies have organized a variety of schemes to arrange for the payment of medical bills over a period of time, etc. None of these plans spreads the economic risk over the group, they are a species of instalment payments."

"Voluntary health insurance has been organized by such groups as the Milwaukee Medical Centre and the Ross-Loos Clinic of Los Angeles. Medical care is provided in return for the payment of regular contributions. The rate for the Milwaukee plan is \$1 a month for one person, and \$3 per month per family. The American Medical Association has opposed this type of development, and has expelled from membership the doctors associated with such ventures."

"As a part of the cooperative movement, certain cooperative groups have organized to secure medical care on a cooperative basis. The Group Health Association in Washington is the best known because of the action of the department of justice in considering the stand of organized medicine as a violation of the anti-trust laws when the doctors who had agreed to furnish medical care to the groups were expelled from membership in the local medical organization, and so lost their right to practise in the local hospitals." (16)

And now, the American people, like ourselves, have been caught tragically unprepared by the war. Already there is a shortage of health personnel for the home front; and new concentrations of population around rapidly growing war industries are creating serious health problems, the major ones being the control of contagious disease and proper obstetrical services.

Canada To-day

Canada has two health insurance plans which are on the statute books, but not in operation. Let us consider them briefly.

British Columbia Plan

The British Columbia act for health insurance was passed in 1936. The income level of \$1,800 per year for employed persons is established with provision for the voluntary insurance of non-employees. Employee's contributions are 2 per cent of wages, and those of employers, 1 per cent of wages; dependents are included. Indigents are not included. Apart from an initial grant for organization purposes, the government was to have no financial responsibility. The only benefit is a medical benefit, no cash benefit being included. The "medical fund" to pay physicians is to be not less than \$4.50 per year insured person. In addition, the insurance practitioner is allowed to charge \$1 for first day-time and \$1.50 for first night-time calls. All office visits are free.

The main objections raised by the medical profession are: the exclusion of indigents, lack of hospital facilities to meet the demand created by health insurance, and inadequate remuneration. And we would add, there was no provision for farm people.

Alberta Plan

The Alberta act for health insurance was passed in 1935. Each resident employed on salary or wages is to pay \$2.01 per month and every employer to pay 81 cents per month for each employee. Non-employees, but income-earners, pay \$2.82 per month. It was estimated that the cost would be \$14.50 per person per year, the employee paying five-ninths, the employer two-ninths, and the provincial government two-ninths. On the basis of one income-receiver per two non-income persons, the income-receiver pays for three persons.

The benefits offered are fairly complete medical services, hospitalization, drugs, nursing care and dental care. Public health services for the medical district would be maintained out of the insurance fund.

In other words, the Alberta plan visualized the province as divided into districts, in which districts public health and medical care services would be made available to all without consideration of income levels. The contributions of the

employed would cover the indigents. The intention was to try out the plan in two demonstration areas, one urban and one rural; but with the change to a Social Credit government, no action was taken.

As we see, the Alberta plan contemplated the contributory system of financing. Where only one province was involved, it was the only way of dealing with the situation; but in a national conception, this burdensome method of financing is no longer necessary.

Some Plans in Operation

Like our friends across the line, we have adopted numerous schemes in the attempt to lift the burden of the cost of medical care from the shoulders of the individual. We have various group hospital schemes across Canada; travelling clinics to serve outlying areas as in Alberta; municipal doctors serving 102 rural municipalities and 68 towns and villages in Saskatchewan (January, 1942) and some 20 municipalities in Manitoba.

There are many plans instituted by industries, which in most cases, do not include dependents, except in such outstanding plans as Consolidated Smelters, Trail, B.C.; the Hollinger plan, Timmins, Ont.; and the Cape Breton "Check-Off" system in Nova Scotia.

In Ontario, the hospital plan gives 21 days hospitalization to the individual. The individual subscriber pays 50 and 75 cents a month for public and semi-private care, the family \$1.00 and \$1.50. Associated Medical Services gives medical, specialist and hospital care at the following rates: \$2.00 per month per subscriber; \$1.75 for first dependent; \$1.50 for second; \$1.25 for third; and \$1.00 for each additional dependent. Farm people find it beyond their financial capacity, as it comes to \$90 a year for a family of five.

In Quebec, rural health units give a public health service to practically all the rural counties. This has been experimented with in a few of the eastern counties of Ontario.

Inadequate Public Health Budgets

In the cities, we have our public health departments. The extent to which these services are developed depends upon the budget available. There is no uniformity in the preparation of health budgets. But it was noted by Dr. Jenkins, medical health officer for Edmonton, that in 1930 only one city in Canada was spending even the minimum amount per person—Toronto, \$1.21. The nearest approach to that was Hamilton with 83 cents—Regina 79 cents—down the line to Halifax with 22 cents. It should also be noted that public health expenditures since 1930 have, in the main, been in a downward direction.

We have already shown public health lacks for rural areas; the insufficient budgets of our provincial health departments; and the opinions of the provinces as a whole regarding their inadequate services. The various attacks on the ravages of ill-health have only served to point out the magnitude of the problem; and we are at last coming to the realization that nothing less than a co-ordinated national attack will suffice—to fill the gaps, cut down on the over-lapping, and use all our available energy along preventive health lines. In effect, hundreds of small toy pistols have been going off in all directions in an attempt to down a monster which is growing to terrifying proportions.

For those of us who are still complacent about health conditions in Canada, we should remember that some 20,000 mothers in Canada each year have no medical attention at the birth of their children; and only $\frac{1}{4}$ of all birth receive pre-natal care. 70 per cent of all deaths of mothers are due to conditions which are preventable or amenable to treatment. (17).

Canada's infant death rate in 1941 (most recent available figure) was 60 per 1,000 live births, and the rate varied from 37 in British Columbia to 76 in Quebec and New Brunswick, and 80 in Prince Edward Island.

Average figures are not enough to show us how bad our conditions are. Toronto is an example of this. We will not be content with our total rates, but examine a well-to-do district as compared with a poor district:—

STATISTICAL DATA ACCORDING TO ADMINISTRATION DISTRICTS—1940

	Yorkville	Moss Park
Per 1,000 population—		
Birth Rate	11.8	16.9
Death Rate	10.9	16.3
Per 100,000 population—		
Tuberculosis	14.4	59.4
Communicable Diseases	1.4	8.5
Per 1,000 live births—		
Infant	25.7	58.6
Maternal	2.9	6.7

These figures clearly indicate the need of localized statistics (which we have already dealt with) and for health centres placed where they are most needed. We anticipate, if these centres are conscientiously set up under health insurance, that the mass of poor people in our large cities will not have to depend on receiving attention in hospital clinics. We are not doing the best for our mothers and children when we compel them to sit all day waiting for attention, mixing up with all sorts of contagion. The working mother who has to lose a day's pay and take her child to a clinic—and in the end, not see the doctor at all—is one of the tragedies of our inadequate system.

Women compose half the population of Canada. We would not think so, when we consider maternal and child health conditions in this country. The women should demand that more attention be given to obstetrics in medical training (18) and that maternity care of the highest quality shall be available in every part of Canada under health insurance.

Great Britain has been in the fortunate position of having an army of well-trained midwives who have nobly filled the breach when so many doctors are required for war service. In spite of all the country has been through, their maternal mortality rate in 1940 was the lowest in their history—2.61 per 1,000 live births. "And here a tribute must be paid to the devotion to duty shown by the midwives, who, it must be remembered, are in attendance at 90 per cent of the births in this country, and in sole charge of 65 per cent." (19)

Is it not wise to thoroughly explore what has and is being done for mothers and children in other countries, and apply that which has proved its value to our own situation?

The Industrial Workers of Canada

There is a greater hazard to industrial production in this war than strikes, and it is going on continuously. It was recently pointed out by Dr. L. B. Pett in a Toronto address that last year, \$50 million was lost in wages by workers, due to illness. From the standpoint of the industrialist \$75 million was lost in production because of this absence from work. Besides the loss in wages, the worker is burdened by the individual bill he has to pay the doctor, hospital or nurse. It has been estimated that the Canadian people are paying annually \$250 million in sickness bills of all kinds. Already then, we have a total of \$375 million, which tops any estimate which has been made for the total cost of a national plan of health for Canada.

Can we afford a national health plan? We see that, in reality, we cannot afford not to have a plan. An examination of the cost of merely one or two items for implements of war shows that the Canadian people are pouring out, for destructive purposes, far more than the cost of a constructive health policy.

The problem was well expressed by an American industrialist, Charles W. Taussig (President of the American Molasses Co., and Chairman of the Advisory Committee, National Youth Administration) when he made his presentation to the National Health Conference at Washington, to which we have already referred:—

"To picture the health needs of the youth who are being aided by the National Youth Administration would only be to repeat in another field the general statistical information that has already been well laid before you . . . The Lindleys touch upon this subject in their recently published book "A New Deal for Youth." They call attention to what we have found to be a typical case in the youth administration. It is the record of a middle-western industrial city where 1,800 boys and girls were given thorough physical examination. Forty-three per cent of them were found to be unemployable by private industry because of their physical condition. . . . We know a great deal more about preventing sickness than we do about preventing unemployment. Yet we courageously explore the economic field, of which we know little, and neglect the field that we have at least partially mastered."

"If I may for a moment speak to you as the head of an industrial corporation, I should like to emphasize the fact that the expenditure of \$850 million for public health does not frighten business. Business bears a far greater financial burden now, due to our neglect of an adequate health control, than its share of the tax burden will be under the proposed plan. The annual toll of preventable illness measured in terms of money runs into millions. Progressive business will regard an adequate health service as a subsidy to industry, not as a burden. The Conference Chairman, Miss Josephine Roche, who is an important industrialist, will no doubt support this point of view. . . . I recognize that what we have been discussing at this conference puts democracy to a severe test; for one of the first questions that we must ask of the democratic process is: Can it meet the recognized social requirements of our people?"

Agriculture

The loss to agricultural production due to sickness is an unknown quantity; because computations on absenteeism have only been made for urban wage-earners. Agriculture has a bigger stake in the field of health than any other industrial group. In the future, for instance, the relationship of soils to health is going to have the attention it deserves. There is great need for research in this field. In Russia, every collective farm has its own laboratory for this purpose. . . .

The rapidly growing interest of the people in nutrition gives us some indication of its importance in national health planning. Our fundamental industry—agriculture—will come into its own. It will produce, not on the basis of our ability to consume under our present economy, but on the basis of human needs.

Canadian Nutrition Surveys

In Canada, nutrition surveys at different income levels have been made in cities across the country; and they show that Canada has a serious nutrition problem. Dr. L. B. Pett, Director of Nutrition Services, in the Department of Pensions and National Health at Ottawa (and also Secretary of the Canadian Council on Nutrition) is conducting a widespread campaign to develop interest in nutrition on a community basis.

He says (20) "What people are we trying to reach? The answer is—everyone The Canadian dietary surveys indicated that while a higher income tends to assure the family of better nutrition, it is no guarantee. Furthermore, these surveys showed serious dietary deficiencies among families of an annual income less than \$1,500. I am informed that this comprises more than

half the families in Canada, so that there is a widespread nutrition problem Therefore, in analysing the meaning of this word 'everyone' it is advisable to be clear that it is not just a case of relief families, or low-income families, because surveys show that even where apparently large amounts of money are being spent on food, yet there may be malnutrition."

Toronto Maternity Nutrition Experiment

The causes of malnutrition are economic, educational—and indifference. The implications of the first two were clearly shown in the experiment which was carried out in Toronto (21). This was undertaken because during the past 25 years, although the number of deaths in infants under one year of age has been reduced because of the decrease in communicable disease, the deaths in the first few weeks of life have altered very little.

Four hundred mothers of low income were studied; and they were divided into three groups. One group found to be on a poor diet was left as a control; a second group on a poor diet was improved by a supplementary diet; and the third, found to have moderately good prenatal diets, was improved by education alone.

The composition of the supplementary diet is interesting—30 ounces of milk, 1 egg and 1 orange daily; once a week, two 16-ounce tins of canned tomatoes and $\frac{1}{2}$ pound of cheddar cheese. At the clinic, wheat germ was distributed, which contained malt and added iron; and vitamin D capsules supplied to be taken daily. The cost of this food (which was to supplement the remainder of the diet from the family income) was \$25 per patient over an average 4.7 months' period.

What was the result? During the whole course of pregnancy, the mothers on the "supplemented" and "good" diets enjoyed better health, had fewer complications and proved to be better obstetrical risks, than those left on "poor" diets. The incidence of miscarriages, stillbirths and premature births was much higher among the mothers on poor diets. The incidence of illness in the babies up to the age of six months and the number of deaths resulting from these illnesses, were many times greater in the poor diet group. In a large proportion, one could tell the diet group of the mother by looking at her baby.

Protective foods have a relationship to the reduction of our high rates for maternal and child mortality and morbidity. The "hollow" hunger which a family of five on low income seeks to assuage by 14 loaves of bread a week, is a mockery, when this bread does not contain all the life of the wheat. More insidious is the "hidden" hunger, which results from the lack of a balanced diet. We are beginning to realize that many of the diseases and breakdowns of various organs in the human body are due to a lack of knowledge of, and ability to pay for, adequate diets.

Production on the Basis of Human Needs

Here is the challenge then—not only to all those connected with the care of mothers and children; but to the primary producers of food. "If we adopt a food policy based on human needs, the first task will be to provide the necessary additional foods. Estimates of the additional amounts of the protective food-stuffs needed to bring the diet of the whole population up to the health level can be made. They have been made for the United States, and it has been found that production of the more important protective foods would need to be increased by the following amounts to feed the whole population adequately on a free-choice basis: butter, 15 per cent; milk, 20 per cent; eggs, 35 per cent; tomatoes and citrus fruits, 70 per cent; green leafy vegetables, 100 per cent. If the United States had these additions to its national larder, the diet of the 45 millions at present below the danger line could be brought up to the safety line." (Dr. Pett at Ottawa is working on a similar computation for Canada. We await the results of his work with keen interest.)

World Food Policy

"If the British Commonwealth joins with the United States on a food policy based on human needs, the pre-war problem of a 'glut' of foodstuffs, surplus to economic demand, will be replaced by a problem of scarcity. Measures of restriction will be replaced by measures in which science will be applied with all its power to increase the production of food. If the sixth article of the Atlantic charter is to be applied in practice so that nations cooperate to give 'all the men in all the lands freedom from want' the prospect of a world glut of food is so distant that it is completely outside the sphere of practical politics. All countries can begin to plan for a prosperous and expanding agriculture." (22)

Effect on Agriculture

Having decided to launch our nutrition campaign, we must look into its effects on agriculture, which every government of every country must maintain in as stable and prosperous a condition as possible. On this foundation depends the prosperity of all other industries. Much of our land has been impoverished by farming methods. It is difficult to replace some of this mineral wealth. The farmer may replace the nitrates; he cannot afford to replace the phosphates. Food products cannot be more nutritious than the soil from which they are produced; so our first care will be to build up and maintain the richness of our soil. Moreover, certain food products are more valuable when grown in one region than in others; so attempts will be made to grow food where it grows best, thus protecting a healthy interchange of farm products. An increase in milk, cheese, butter, eggs, vegetables, and fruit require more man power than the cash crops; and the new demands on our agriculture will require more men on the farms.

More farmers will find work, more farm machinery will be needed, more food will pay freight, more grocers would profit, more red blood would flow through the veins and arteries of commerce. In fact, the results would make its influence felt in every part of our economic system. This policy of agricultural expansion to meet human needs for food, will have a profound effect upon industry and trade all over the world. Agriculture will have to be made efficient to enable it to produce the additional foods needed.

The farm people of Canada, through their national farm radio forums are making a study, not only of their place in the national economy, but in the world economy of to-morrow. In the field of health, they hold a foremost place; not only because of their own needs, which have received too little attention in the past, but also because of the contribution they will be called upon to make in the immediate future. Let them apply themselves more diligently than ever to their educational movement.

The Federation of Agriculture feels that a great deal of the success of this movement to date is due to the assistance of the Canadian Broadcasting Corporation and the Canadian Association for Adult Education.

The Dental Profession

As in other fields, their rate of production has been controlled by the ability of the public to assimilate their services . . . and that has been based on the ability to pay. To-day, for instance, we have no more dentists than we had according to the 1931 census.

The leaders in dentistry acknowledged this lack when they made their recent submission on health insurance to the Dominion government. They point out that to tackle the problem all the available dentists will have to devote their energies in the main, to the child population, while building up their required numbers. Because of this viewpoint, which is both logical and

praiseworthy, they are interested in any survey which shows a condition of positive dental health, rather than that of the negative state which prevails to-day.

In this connection, they are studying with care the records and X-ray photographs of a large group of children who have been born and are growing up under the guidance of the Canadian Mothercraft Society. The mothers of these children have had the highest degree of health education, pre-natal care and good diets; their children were breast-fed, and have been under constant supervision and guidance in the pre-school and school years. They show such a superior development, in general physique as well as dental, that the doctors and dentists connected with the survey are convinced that if we followed sound principles of natural foods and proper care and education of all mothers, we could cut down the incidence of tooth decay, and raise the standard of mothers and children of the future.

Hospitals and Nurses

Our hospitals are labouring under impossible conditions. Where group hospital plans have been in operation for some time, it is noted that they are "out of the red." But the average hospital, in an attempt to compensate for free patients in public wards and clinics, has applied "the sliding scale" so that the rich and those of moderate income have had to pay high costs for hospital care. Meanwhile, outside municipalities have ever-rising bills for indigent care in city hospitals; and at their county council meetings they are passing innumerable resolutions in favour of the nationalizing of hospital care.

In an attempt to cut down on their overhead, hospitals reduce their staffs, with the result that nurses are overworked, often to the point of endangering their health; and patients, unless they can afford a special nurse, often do not receive enough attention. The war has accentuated the problem of hospital economics, and many are working with reduced equipment, because replacements are impossible.

The public complains that it cannot afford to pay \$6.00 for a nurse on an 8-hour shift (higher for mental or infectious cases) and this has led to the increasing demand for the service of the practical nurse. But nurses are not getting rich. After they graduate they waste a great deal of time waiting for cases. Dr. G. M. Weir's "Survey of Nursing Education in Canada", showed the average private duty nurse was employed 29.9 weeks out of the 52. Yet, while nurses are unemployed, people are going without care. The nursing survey in Ontario in 1938 showed that 80 per cent of those who were deprived of nursing attention could not afford it.

The whole situation is a vicious circle. Under a national plan for health, we would expect to see a complete change for the better, with hospital care and nursing based on human needs; and that, with no financial hazards, the average standard of care would be raised, while the staffs will be commensurate with the needs of hospitals instead of their overhead. Wings for convalescent patients would cut down the overhead of hospitals considerably, as well as speed recovery.

Other Health Professionals

There is no doubt that one of the questions in the minds of the public to-day is—What about other professionals in the health field, whom they have become accustomed to using, and whose services have been of benefit? In other words, what about osteopaths and chiropractors? To our mind, there are two procedures to be followed: either that these services should be recognized under a national plan; or that their work should be incorporated into the course of medical training. This is a situation the public expects to be clarified.

The Medical Profession

What is the attitude of the profession towards national health insurance? Judging by the replies which were received to the questionnaire sent out by the Canadian Medical Association to the doctors across Canada, approximately 21 per cent answered, on the supposition that there are around 11,000 in Canada. Thus, the opinion of the majority is an unknown quantity. All the same, some interesting deductions can be made from this questionnaire, based on the eighteen principles as put forward by organized medicine.

In Principle No. 8, it is advocated that a level of income should be determined below which people shall be participants in the plan. 'We have pointed out earlier that this is not in the interests of the health of all the people of Canada. Up to the present time, the tendency of the medical profession has been to vary its fees in accordance with the economic status of the patient ("the sliding scale") and the inability to collect payment on a high percentage of the services billed; or, in other words, the doctor's paying patients supposedly compensated him at rates sufficiently high to cover the time which he devoted to clinics, hospitals and other non-remunerative work. Also, it takes about eight years for him to build up a practice. High costs of overhead, and distance to rural calls have been other factors contributing to the costs of medical care.

In the future, all these things will be wiped out by health insurance. Thus we see no reason why any group of the population needs to be penalized, or to be deprived of the benefits of the kind of service we visualize for the future—not "poor man's medicine" but the highest type of preventive medicine on a family basis, whether they are rich or poor.

Also, it must be realized that up to the present, a minority in the medical profession has been situated so they could demand high fees; but the great majority have had patients with variable incomes, low incomes or no income at all. "Rugged individualism" has resulted in a multitude of far from rugged individuals—amongst both doctors and patients. In justice to the great majority of doctors, who have given their services unstintingly under tremendous odds, we wish to point out that under a national plan, the Canadian people wish a just reward for all doctors, as well as a just service for all the people.

Principle No. 14 advocates that health insurance shall be based on the schedule of fees as laid down by the medical profession of each province. The average citizen is amazed that any one group should assert such a principle. Nobody proposes to turn over medical services to the control of politicians. Nobody contends, for instance, that a board of aldermen should decide when to operate for appendicitis. The practice of medicine, nursing or dentistry is the responsibility of the professions concerned. But the question of how these services shall be paid for is very much the concern and responsibility of the public.

When John Public scrutinizes the schedule of fees, as set forth by the Medical Association, he is appalled by the multitude of procedures to which the human body may be subjected, under the advances of medical science. He finds over 300 procedures, varying from \$10 "and up" for an ingrowing toe nail—to \$250 "and up" for a laryngectomy. All of these 300 procedures have no "ceiling"—the sky's the limit, supposedly. How can all this be encompassed by a plan to cover all citizens? This is what is puzzling the public, as well, no doubt, as the unfortunate actuarial experts.

The matter is further complicated by the fact that most of these procedures depend on the work of specialists; and except for one Canadian province, there is no law specifying who is, or is not, a specialist. In 1930, Dr. W. Harvey Smith made special mention of this in his presidential address before the Canadian Medical Association:

"Of recent legislation in Canada dealing with medical practice, that which stands out preeminently in its claim to attention is the statutory regulations of specialists in the province of Alberta, which is the most advanced legal enactment of its kind in this country. It provides that no practitioner can hold himself out to the public as a specialist in any recognized field of special practice, unless he has received from the senate of the university of the province, a certificate that he has complied with certain specific requirements as to study and experience. Under this arrangement, bona fide specialists and the public of Alberta, are being protected against uninstructed, unskilled persons announcing themselves as specialists. The Alberta legislation is unquestionably in the direction of a higher standard of education and competency in specialized, and indeed, in general practice as well. I feel justified in saying that it will be but a matter of time until the other provinces follow the excellent lead thus given."

So far, nothing further has been done to protect the practice of medicine and the public. As late as September, 1941, we note that the Ontario Medical Association Bulletin stresses the need in the following words: "Insurance scheme makes classification and authorization of specialists more imperative."

Dr. E. A. McDonald, when he was President of the Toronto Academy of Medicine, in 1933, suggested a State Medicine Plan to the Association (23) whereby general practitioners would be paid salaries of \$6,000 and specialists \$8,000 to \$10,000 a year. Certainly, this would simplify the computation of the total cost of a national plan.

And if, for instance, the health workers working in conjunction with the health centres in a national plan, were assured of good incomes, and increases commensurate with the degree of progress of preventive medicine in their area, we feel that a true competition would begin to function, far superior to the individual competitive system which has prevailed in the past.

THE FUTURE

By law, we have made it compulsory for all our children to have education; but we have not done the same for health. In the future, education will not have to accept the faulty human material we have presented to it; instead we will see that every child has the best chance for mental and physical development before they all come together under our school system. Education and health will then go hand in hand, to the untold advantage of both.

What we should have in Canada is an annual children's health crusade, when the young citizens of Canada would meet in our capital cities—or better still, in our great national parks. The tragedy at present is, that Canadians do not know their own country. Most of them live and die in a corner of one province, and know nothing of the marvels of Canada or of the different viewpoints which prevail from the Atlantic to the Pacific. What better bond of union than to have our children mix and see Canada from coast to coast in the summer months. These great migrations would be an inspiration to us all; and through our children we would begin to achieve understanding and unity.

We ourselves are only stepping-stones to the future. A generation hence, our children will look back, and say whether or not we planned wisely and well, in the great endeavour to achieve complete nationhood after the war.

To achieve success in national planning of any kind, co-operation is a necessity. Surely we are not afraid to think objectively of our problems and to apply the results of that thinking!

We need an orientation of our thinking. Great truths are waiting to be discovered and applied for the good of humanity. If we merely applied what we already know, the world would be a very different place.

If the war has not already taught us this truth—that we are all fellow passengers on the same planet, and the health, happiness and well-being of all of us is the concern of each one of us—then our youth will have died in vain.

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4. Public Health—A study prepared for the Royal Commission on Dominion-Provincial Relations, by A. E. Grauer. Pages 74-75. Note: Provincial figures not compiled on exactly the same basis; but this is a good approximation.
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The Socialist Sixth of the World, by the Dean of Canterbury.
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17. Dr. Ernest Couture, Director of Maternal and Child Hygiene, Department of Pensions and National Health, Ottawa.

18. "In no Canadian medical school to-day is obstetrics anything but a 'pass subject' requiring only 50 to 60 out of 100 for examination credit." From *Need Our Mothers Die?* A study made by a special committee of the Canadian Welfare Council.
19. *Mothers and Children in Great Britain*. From the report of the British Ministry of Health. Quoted in the *National Health Review*, Department of Pensions and National Health, Ottawa, July, 1942.
20. *A Canadian Nutrition Programme*. Dr. L. B. Pett. *Canadian Public Health Journal*, July, 1942.
21. *The Influence of Prenatal Diet on the Mother and Child*. Drs. J. H. Ebbs, F. F. Tisdall and W. A. Scott.
22. *Fighting for What?* Sir John Boyd Orr.
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The CHAIRMAN: We will adjourn until Tuesday next at 11 o'clock.

The committee adjourned at 12.45 p.m. to meet again on Tuesday, May 18, 1943, at 11 o'clock a.m.

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Canada Social Security, Spec. Ch.

SESSION 1943
HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

(SOCIAL SECURITY)

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 11

TUESDAY, MAY 18, 1943

WITNESSES:

- Dr. B. T. McGhie, Deputy Minister of Health and Hospitals for Ontario;
- Dr. L. R. Vezina, Ministry of Health, Quebec (Chief, Division of Mental Hospitals);
- Dr. C. B. Farrar, Professor of Psychiatry, University of Toronto;
- Dr. J. P. S. Cathcart, Chief Neuropsychiatrist, Department of Pensions and National Health, Ottawa.

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MINUTES OF PROCEEDINGS

TUESDAY, May 18, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Bourget, Breithaupt, Bruce, Casselman (*Mrs.*) (*Edmonton East*), Claxton, Cleaver, Coté, Donnelly, Fauteux, Fulford, Gershaw, Hatfield, Howden, Hurtubise, Kinley, Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, Maybank, Mayhew, Shaw, Veniot, Warren, Wood and Wright.—34.

Dr. J. J. Heagerty was requested to introduce the witnesses. He introduced Dr. B. T. McGhie, Deputy Minister of Health and Hospitals, for Ontario. Dr. McGhie, in turn, introduced the following persons:—

Dr. L. R. Vezina, Minister of Health, Quebec (Chief, Division of Mental Hospitals).

Dr. J. P. S. Cathcart, Chief Neuropsychiatrist, Department of Pensions and National Health, Ottawa.

Major S. R. P. Montgomery, Psychiatrist, R.C.A.M.C.

Dr. G. H. Stevenson, Professor of Psychiatry, University of Western Ontario.

Dr. L. S. Penrose, Acting Medical Statistician, Provincial Department of Health, Toronto.

Dr. C. B. Farrar, Professor of Psychiatry, University of Toronto.

Dr. F. H. Baugh, Superintendent, Homewood Sanitarium.

Dr. C. H. McCuaig, Professor of Psychiatry, Queen's University, Kingston.

Dr. McGhie presented a brief on Mental Diseases and was examined by the Committee. Tables printed as Appendix "A" to this evidence.

The following were also called and examined: Drs. Vezina, Farrar, Stevenson, and Cathcart.

The Chairman thanked the witnesses who then retired.

Mr. P. R. Bengough, Acting President of the Trades and Labour Congress of Canada was called and presented a brief on behalf of that organization. After being examined by the Committee the witness retired.

The Chairman announced that on Tuesday, May 25, Sir William Beveridge would appear as a witness before the Committee.

The Committee adjourned at 12.45 p.m. to meet again Friday, May 21, at 11.00 o'clock a.m., when the Canadian Public Health Association would be heard.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

May 18, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Order, gentlemen. This morning we shall discuss mental health, and I shall ask Dr. Heagerty to introduce the witnesses.

Mr. WRIGHT: Mr. Chairman, I should like to say a word before the committee starts hearing our witnesses to-day with regard to what took place at our last meeting. We had a representative here from the Canadian Federation of Agriculture to present a brief to the committee, and we had a government official here, Dr. Couture, to present a brief on behalf of the department. That was a very good brief and one which the committee should have heard. But the Canadian Federation of Agriculture sent a representative here from the city of Toronto—a very busy man—and all the time we left him in which to present his brief was half an hour. Now, as a member of the committee I think that when we ask someone from outside of Ottawa to come here to present a brief that brief should be presented first rather than that we should receive a brief on behalf of some official of the department. I think that is only a matter of courtesy to those who are presenting briefs to us, and I desire to bring that to the attention of the committee.

The CHAIRMAN: Thank you, Mr. Wright.

Dr. HEAGERTY: Mr. Chairman and members of the committee, I am going to introduce to you Dr. McGhie, Deputy Minister of Health and Hospitals of Ontario. We have had Dr. McGhie with us, you will recall, before when the province of Ontario health officers discussed the administration of health insurance. Dr. McGhie, in addition to being deputy minister, in the field of public health looks after hospitals, a field in which he has had long years of experience; and particularly in that field he has had to do with mental hospitals. Dr. McGhie has brought with him to-day a number of gentlemen who are authorities in the field of mental health, and I am going to ask Dr. McGhie, before he presents his brief, to introduce these men to us.

Dr. B. T. MCGHIE, Deputy Minister of Health and Hospitals, Province of Ontario, Called.

The WITNESS: Mr. Chairman, Mr. Minister, ladies and gentlemen, associated with me here this morning in the presentation of this brief are the following persons: Dr. Vezina, Ministry of Health, province of Quebec, Chief of the Division of Mental Hospitals; Dr. Cathcart, Chief Neuropsychiatrist, Department of Pensions and National Health, Ottawa; Major S. R. P. Montgomery, Psychiatrist, R.C.A.M.C.; Dr. G. H. Stevenson, Professor of Psychiatry, University of Western Ontario; Dr. L. S. Penrose, Acting Medical Statistician, Provincial Department of Health, and working part time in one of our mental hospitals in London, where he is carrying on research work; Dr. C. B. Farrar, Professor of Psychiatry, University of Toronto; Dr. F. H. Baugh, Superintendent, Homewood Sanitarium; Dr. C. H. McCuaig, Professor of Psychiatry, Queen's University.

Now, Mr. Chairman, ladies and gentlemen, in the presentation of this material, I should like to refer to the men from the various provinces who

have had a part in its preparation. Dr. Jean Gregoire was good enough to have Dr. Vezina sit in with us on several occasions, and he is familiar with the material as it is presented. Others who have assisted in the preparation of the brief are:

Dr. R. D. Defries, Professor of Public Health, University of Toronto;
 Dr. F. W. Jackson, Deputy Minister of Health and Welfare, Winnipeg;
 Dr. J. T. Phair, Chief Medical Officer of Health, Ontario;
 Dr. J. P. S. Cathcart, Chief Neuropsychiatrist, Department of Pensions and National Health, Ottawa;
 Dr. M. R. Bow, Deputy Minister of Health, Alberta;
 Dr. R. O. Davison, Deputy Minister of Health, Saskatchewan;
 Dr. J. W. MacNeill, Superintendent, Provincial Hospital, Saskatchewan;
 Dr. J. A. Pincock, Provincial Psychiatrist, Winnipeg;
 Dr. L. R. Vezina, Ministry of Health, Quebec;
 Dr. E. C. Menzies, Saint John, N.B.;
 Dr. R. W. MacKay, Dartmouth, N.S.;
 Dr. A. J. Murchison, Charlottetown, P.E.I.;
 Dr. G. H. Stevenson, Professor of Psychiatry, University of Western Ontario;
 Dr. C. B. Farrar, Professor of Psychiatry, University of Toronto;
 Dr. C. H. McCuaig, Professor of Psychiatry, Queen's University;
 Dr. C. M. Hincks, Director, Canadian National Committee for Mental Hygiene, Toronto;
 Dr. F. H. Baugh, Homewood Sanitarium;
 Dr. C. H. Skitch, Verdun Protestant Hospital, Montreal;
 Major S. R. P. Montgomery, Psychiatrist, R.C.A.M.C.;
 Surg. Lt.-Cdr. M. Wellman, Psychiatrist, R.C.N.;
 Wing Commander H. D. Mitchell, Psychiatrist, R.C.A.F.;
 Dr. W. O. Gliddon, Neuropsychiatrist, Department of Pensions and National Health.

In discussing the question of mental illness and health insurance we propose to present the subject under the following headings: introduction; prevention; treatment; costs; summary; appendix:

1. *Introduction*

The wide field of mental illness constitutes the largest special medical and hospital problem in Canada. (See Appendix 1.) The field of psychiatry has expanded tremendously within recent years. The question of patients in mental hospitals, which formerly was practically the sole concern of the psychiatrist, is now only one of many divisions in this field.

The health of the community has been called one of the foremost concerns of government, and health includes inseparably both physical and mental well-being. Problems of mental health and ill-health begin in the earliest years of childhood. The problems continue in the school where cases of retarded mental development are often first recognized and where early and perhaps reversible symptoms of actual mental illness are also observed. Later, in industry, success or failure may be as much a question of mental stability as of physical fitness. Moreover, all social relations and community organization depend upon the wholeness of individual personalities. Finally, medicine now recognizes the great importance of the mental aspect of all illness, and indicative of this fact has been the marked shift in the attitude of the medical profession whereby the fields that have been called "general medicine" and "psychological medicine" have merged into what is now called "psychosomatic medicine".

The field of mental illness covers a variety of conditions which can be classified under the general heading of "psychopathic states". They occur at all ages, from infancy to the last decades of life, and require many different types of facilities for diagnosis and treatment. The chief psychopathic states are as follows:

1. Mental disorders—including mild and severe forms of both "neurosis" and "psychosis"
2. The epilepsies
3. Mental defect
4. Addiction to alcohol and narcotic drugs
5. Psychopathic personality

The terms "insanity", "psychosis", "mental illness", which in usage mean much the same thing, have been applied to conditions with which the general practitioner as a rule does not wish to deal and with which most general hospitals do not wish to deal, although both general practitioner and general hospital are prepared to deal with all other medical conditions. On the other hand, so-called "nervous" conditions, the "neuroses", have commonly been found suitable for treatment both by the general practitioner and the general hospital. Thus, an unfortunate distinction has been maintained, with sinister implication for the patient suffering from "mental illness". Occasionally, in the lay mind and too often in the professional mind, it is mainly the apparent seriousness or conspicuousness of symptoms which determines whether the case shall be called a psychosis or a neurosis. In actual fact, however, the field is one and the separation merely artificial. The family physician and the medical officer of health must be prepared to consider all aspects of health, physical as well as mental.

The number of cases presenting themselves for psychiatric care is steadily increasing, apparently somewhat more rapidly than population growth. We should not take this as evidence that mental disease is on the increase. The increase is largely due to recognition of milder cases, formerly disregarded, and to the growing tendency to bring cases earlier to medical attention, likewise, to the widening recognition by physicians that a large part of general practice problems centres in the personality and mental life of their patients. Estimations by physicians in active practice have shown that from 20 per cent to 70 per cent of their patients present psychiatric or mental hygiene issues, which are either the essential feature of the case or complicating factors which equally require attention in the treatment programme. It would probably be fair to say that 50 per cent of all patients visiting doctors' offices are not exclusively cases of physical illness but have psychological problems as well.

2. PREVENTION

In the first place, obviously, the family medical adviser of to-day and of the future must have some acquaintance with both preventive and curative aspects of mental illness. On the preventive side he must be able to apply the principles of mental hygiene in dealing with illnesses and difficulties of childhood and of school children and, likewise, with many industrial disabilities involving questions of fatigue, friction and general inefficiency. He must recognize the psychological aspect of disturbed home and family relationships and the psychopathology of marriage. On the treatment side, he must be able to apply any possible corrective measures in all of these conditions.

Crucial are the many problems of adolescence in which medical advice is sought, and in which proper measures taken in time may avert disastrous results which would otherwise follow. At the turn of life in the involutional period and in old age, questions of wholesome living arise which are really psychiatric problems and should be dealt with as such.

It will be seen that the bulk of these matters, which are definitely questions of the mental health and stability of the individual and of the community and need treatment like any other disabilities, do not require hospitalization at all. They are problems of the increasingly important field of preventive medicine in its broader interpretation.

The seriousness and scope of these problems have been more keenly appreciated within recent years but means to deal with them are inadequate. Between the mental hospital on the one hand and the general hospital with its out-patient services on the other, there is a broad health field which is not effectively covered. The first requisite is trained personnel. This means that the curricula in medical schools should be amplified to qualify students in preventive psychiatry just as in preventive medicine generally; that opportunity should be provided for physicians in practice to get some training and experience in this field; that in the allied services—nursing, social service, occupational therapy and education—training in mental hygiene should uniformly be provided both for undergraduates and graduates.

It may be mentioned here that psychiatry was the original form of state supported medical care. The relationship between mental institutions and general hospitals has unfortunately never been very close, although it has been improving in recent years. This circumstance has contributed in the past to keep psychiatry and general medicine apart. The separation has been unfavourable not only for psychiatry and for general medicine but also for the patient. It is no doubt in considerable part responsible also for a relative lag in psychiatric research and education. Fortunately, the earlier barriers between these intimately related fields are breaking down; but there is urgent need for more vigorously promoting the inter-relationship between psychiatry and the other medical sciences. The recent emergence of many new forms of treatment is evidence that the process is going on.

The most important step toward integration of the medical fields has been the establishment of full psychiatric services in general hospitals. One may question whether a hospital deserves the title "general" which does not provide psychiatric service. The Henry Ford Hospital in Detroit might be cited as an example of a general hospital which for twenty years has maintained a complete psychiatric service. The experiment proved to be entirely successful. Patients are admitted without legal formalities, there is free transfer of patients between the psychiatric and other wards; and internes, nurses and staff physicians get experience in dealing with both the physical and psychological features of illness, obtain a more adequate conception of both and thus become better physicians and nurses.

As has been mentioned, the most important field in psychological medicine is outside the mental hospital and in the community. This importance is due not only to the bulk of the material but also to the fact that in this field there is the greatest hope for the success of preventive measures. It is here that travelling mental health clinics play so large a part. Their value has been amply demonstrated in several provinces. Hitherto these clinics have travelled out from the provincial hospitals. This relationship at the present time is only one of convenience, and such clinics should be more closely integrated into the community health program. They could also be based on public health centres in the various districts. They would have a regular schedule of visits to surrounding communities serving areas, which altogether would equal the dimensions of the province. The clinics would handle cases, voluntarily seeking advice and help, and cases referred by parents, teachers, physicians, social agencies and courts. They also can help in the education of the public on mental health matters through personal contacts and lectures. By such means it should be possible to keep in the community, and often wholly or in part self-supporting, many persons

who would otherwise eventually have to be provided for in the provincial hospital. The institution of these clinics necessarily involves a greatly increased psychiatric staff, including physicians, social workers and psychologists.

In a complete service which would deal adequately with both the prevention and curative aspects of mental illness, the preventive work would be taken care of largely by the mental health clinics above mentioned. The hospitals, both mental and general, and including in- and out-patient services, would provide for active treatment cases. Under after-care would be included not only the regular follow-up of discharged patients, but particularly a greatly expanded boarding-out system.

In the expansion of psychiatric staff, attention should be given to specially trained social service personnel. These workers are indispensable in all phases of the provincial system—in the preventive work of the travelling clinics, in in- and out-patient hospital services, in follow-up and after-care and in the supervision of patients in boarding-out homes. In connection with preventive work it would be highly advantageous to have sufficient social service staffs at hospitals or health centres to answer the frequent calls which come from the community for assistance in dealing with psychiatric problems not readily handled through one of the regular channels. Workers at present attached to the various social agencies for the most part lack psychiatric training, to their great disadvantage.

In any remodeling of provincial psychiatric services, the question of legal formalities deserves serious consideration. The legal formalities now required for the treatment of psychiatric patients in hospitals are often painful to patients and their relatives and prejudicial to patients' interests. These formalities have contributed to the separation of psychiatry from general medicine, and foster the so-called stigma attached to mental illness. A psychiatric disability is the only kind of sickness which requires a separate and individual process of law to get a patient under treatment in a hospital. This anomalous situation is a residual consequence of an earlier social attitude toward mental illness, when laws authorizing confinement of persons "insane and dangerous to be at large" were made for the protection of society and not primarily with the welfare of the mentally sick person in view. In later years, as the focus of attention shifted gradually to the protection and well-being of the patient himself, the laws were modified in the direction of safe-guarding his interests. In the main, however, the declaration or implication that he is unsuitable to be at large, that he is not of sound and disposing mind and is therefore to be regarded as irresponsible and that he may be legally deprived of his liberty, remains an unpleasant formality which serves in no way the purpose of treatment.

In order to ensure the progressive improvement of all methods of control of mental diseases, future planning should include ample facilities for scientific research into the causes and treatment. For this purpose, research units can be established at centres where clinical material and laboratory facilities are available. Individual staff members at any centre should also be given time and opportunity to study specific problems. The organization of the services must leave room for the careful analysis and appraisal of the results of the forms of preventive or curative treatment advocated from time to time.

3. TREATMENT

A brief statement concerning the treatment needs of each of the chief types of psychopathic state now follows.

1. *Mental Disorders*

Neuroses, often called "nervous" conditions, are mental disorders. These are very numerous among children and adults but most cases can be treated at home or by office practice. If hospitalization is needed, most such cases can be cared for in general hospitals, very few requiring mental hospital care.

The cases of psychosis or "insanity" comprise the largest group requiring hospitalization. During the incipient stages, intensive treatment at home, by mental health clinic, or by a psychiatric ward in a general hospital may prevent acute symptoms and lead to recovery. Where such treatment is unsuccessful, mental hospital facilities should be made available. It is estimated that there should be at least four beds per 1,000 of the general population. Most mental hospitals are seriously overcrowded, insufficient beds having been made available in proportion to the needs of the population. A mental hospital should be operated in accordance with the "minimum standards" which were set up by the American Psychiatric Association in 1925 and re-affirmed from time to time since. (See Appendix 2.) This association is an international one and the "minimum standards" were drawn up by a special committee appointed to study the problem and which included a Canadian member. These standards, although necessarily modified in some respects in war time, represent the indispensable conditions of mental hospital management and effective service to the mentally ill. To build a properly constructed and equipped hospital to accommodate 1,000 to 2,000 patients would cost \$2,500 to \$3,500 per bed. Additions to existing hospitals could be built in most cases for \$1,500 to \$2,000 per bed. The "family care" plan of caring for mentally sick persons (to be described later) could obviate this capital outlay and maintenance charge for as many patients as can satisfactorily be cared for under that plan. It might also be noted that the actual cost of patients in hospital varies with individual provinces but will usually be between \$7 and \$8 per week. This contrasts with \$5.50 to \$7 per week for patients in family care including cost of supervision and incidental expenses.

2. *The Epilepsies*

Epileptic persons constitute about 250 to 400 per 100,000 of the population but most of these can be treated at home or by office practice. Only the more severe cases, including uncooperative, dangerous and mentally disordered require special hospital facilities, at the rate of 25 beds per 100,000 of the general population.

3. *Mental Defect*

These constitute about 1,000 to 1,500 per 100,000 of the general population, but only 100 to 150 per 100,000 require special institutions for training, treatment and care. The great majority can be cared for at home and trained in the auxiliary classes of the school system.

4. *Addiction to alcohol and narcotic drugs*

Although the smallest group of psychopathic states, it represents a distinct problem in treatment. Most provinces at the present time provide care and treatment for this group only on the wards of mental hospitals, although some are cared for in general hospitals and others in penal institutions. Because of the close relationship of addictions to mental disorders, it is recommended that a separate building, especially equipped, with full treatment facilities be provided. Further it is suggested that such an institution should be operated by the federal government.

5. *Psychopathic personalities*

While many persons may have individual peculiarities, oddities or eccentricities, there is a considerable number whose personalities are so weak, warped, or pathologically eccentric from birth or early life that, without being intellectually deficient, they never succeed in making a satisfactory adjustment to life or of becoming useful citizens. Many of these sooner or later come in conflict with the law and thus are seen in our courts or penal institutions. No province at

the present time takes official cognizance of this group in its mental hospital acts, but the fact that such a group exists warrants the use of psychiatrists and psychologists in our courts and penal institutions, for the proper diagnosis and treatment (advisory to the court) of all persons committing crime. Other types of psychopathic states may also in whole or in part cause anti-social behaviour, such as mental deficiency, epilepsy and certain psychoses, which constitute additional reasons for better psychiatric and psychologic facilities than exist at present.

Special Treatment Facilities for Psychiatric Disorders.

(a) *Mental Health Clinics.*—These have already been referred to under preventive measures. Their importance for consultation and treatment, particularly of the less severe or incipient conditions needs emphasis. Travelling from city to city and using the out-patient facilities of general hospitals, enables them to work in close cooperation with physicians, hospitals, schools, courts and welfare organizations. For the dual purposes of prevention and treatment, one clinic, consisting of psychiatrist, psychologist and one or more social workers, with adequate clerical assistance can serve approximately 200,000 people in urban areas or 100,000 in rural areas.

(b) *Psychiatric Wards in General Hospitals.*—The realization that the mentally sick are really sick people who may need very complete examinations and consultations for diagnosis and adequate treatment calls for the establishment of properly equipped wards in all general hospitals of fifty beds or more (and at least one or more properly equipped rooms in smaller hospitals). Limitations of time and space do not permit a lengthy discussion of this most important development but we feel it is essential to the proper care of citizens who may develop mild or severe mental disorders. Such a ward would be for short treatment only; prolonged illnesses would be cared for in mental hospitals.

(c) *The Elderly Mentally Ill.*—The actual number of people above the age of sixty is gradually increasing in relation to the younger age groups. There are also certain disease processes which occur more frequently in the latter decades of life, such as nutritional disorders and diseases of the heart, arteries and brain. Since these elderly persons constitute such a large proportion of citizens, it is important that they receive the medical attention necessary for their welfare. As a parallel to hospitals for sick children and the specialty of paediatrics generally, it is recommended that separate facilities (at existing provincial hospitals or otherwise) be provided for the treatment of elderly people and for research investigation into their health problems, a specialized field of medical practice now known as geriatrics. At the present time people above the age of sixty constitute more than 20 per cent of the admissions to mental hospitals adding definitely to the problem of overcrowding. (See Appendix 4.) It is recommended that hospitals for elderly people be suitably staffed and equipped to care for all types of illness common to advancing years, including mental illness.

(d) *Family Care of Mentally Sick Persons.*—The family care or boarding-out system means that selected hospital patients are placed in approved homes in a community within convenient access to the hospital, where they can be cared for with a minimum of supervision and lead as active a life as possible. The hosts in boarding-out homes are instructed as to necessary care and precautions. These patients are carried on the books of the hospital and may be returned to the institution without formality if occasion requires, and the hospital remains responsible for their maintenance and care until they are suitable for discharge in the regular way. Supervision could be maintained

by a mental health clinic where such clinic is attached to the hospital, otherwise the hospital would have to supply medical and social service personnel adequate to take care of the boarding-out patients.

It has been demonstrated by the experience in California that this system can be greatly expanded with advantage to all concerned. By making the boarding-out plan one of the primary objectives of the state service, California has achieved the record figure of more than 21 per cent of the total number of patients on the books of these mental hospitals now placed in boarding-out homes. In Ontario, between 3 and 4 per cent of all patients on the books are now placed under family care.

The boarding-out system serves three purposes: (a) it provides the most suitable form of treatment for many patients; (b) it measurably relieves overcrowding in hospitals; (c) it reduces the need for new construction.

(e) *Private Accommodation.*—As suggested in the federal recommendations for health insurance, all citizens who require it will be entitled to free hospitalization for mental illness. It is therefore recommended that provincial hospitals be equipped and staffed to give adequate standard care and treatment, leaving to the private sanatoria the field of providing extra amenities for those patients who desire to pay for such extras, at least for a period of time, until the prognosis can be determined. In those provinces where private accommodation exists, the provincial authority, with dominion assistance, might well pay towards the maintenance of each patient an amount equal to the per capita cost of standard care and treatment. The Private Sanitaria Act in each province might be amended to protect the interests of all concerned.

General Comments

With free mental hospital care authorized for all who need it, there is likely to be a greatly increased demand for such care. The two main groups for which such additional accommodation will be needed are the mental defectives (adults and children) and the elderly mentally sick. The reason for this expected increased demand is not that there will be an increase in the actual numbers of persons so affected (although this may become a factor with the old age group) but rather that if the government is to give free care to all such persons, those now being cared for by private families and at private expense will wish to be relieved of this care and expense. It should be noted also that mental hospitals are practically all overcrowded (10 to 35 per cent) and the public may be unwilling to tolerate continued overcrowding, which would interfere (as it does at present) with healthful and efficient care and treatment. (Appendices 1 and 3).

4. COSTS OF THE MENTAL HEALTH SERVICES

The gross cost to a province of caring for a resident patient in a mental hospital amounts to a little more than \$7 weekly of which more than half is spent on salaries and wages. This estimate covers the cost of mental health clinics and other special treatment facilities as they are at present organized. Throughout the dominion there were, on December 31, 1940, 44,163 patients in residence in mental hospitals and the annual gross cost of maintaining this number is approximately \$20,000,000. The special question at issue in connection with proposed health insurance legislation is what proportion of the gross cost expended by the province should be recovered from the federal government under the proposed scheme. An estimate of one-ninth for this proportion has already been put forward but the consensus of opinion of the administrative authorities in the province is that this figure is too low and should be advanced to one-quarter. The proportion eventually agreed upon should be applied to the daily average gross per capita cost of patient maintenance.

The following points have been made in support of this view:

1. In certain provinces, where a large number of patients contribute towards their own maintenance, the amount forfeited if all patients were treated free of charge would be much more than one-ninth of the gross cost of care for all patients. (See appendix 4). In some instances the revenue from patients has at times exceeded one-third of the gross expenditure.

2. In provinces where it has not been possible to reclaim from patients more than a small proportion of the expenditure, this has been due to exceptional conditions such as agricultural depression and must not be considered normal for the dominion.

3. If there is to be an extension of mental health services in the manner described in the earlier part of the report, by enlarging the preventive mental health services and outlaying capital expenditure for new wards or buildings, there would be need for federal assistance which could not be covered by so low a figure as one-ninth of the provincial expenditure.

4. Health insurance is likely to increase the demand for hospital facilities chiefly among those groups of persons who are now spending their money in keeping patients out of hospital. This means that there will be a virtual increase in the proportion of paying patients in the hospitals, which is not allowed for in the one-ninth estimate.

5. SUMMARY

The recommendations put forward in this brief are summarized in the following suggested plan for a complete mental health service.

- (a) Out-patient psychiatric service for children and adults, in general hospitals.
- (b) In-patient psychiatric wards for children and adults, in general hospitals.
- (c) Travelling and/or stationary mental health clinics.
- (d) Mental hospitals for long treatment cases which shall include the following types of organization:—
 1. centre for tuberculous mental patients.
 2. centre for neurosyphilis and post-syphilitic conditions.
 3. centre for elderly and senile cases.

These are to be centres in existing mental hospitals.

 4. farm colony and industrial centre for long-duration cases not requiring active treatment.
 5. hospital or separate ward for convulsive disorders.
 6. training school for defectives—all ages—separate institutions (in large provinces) or divisions of existing institutions (in small provinces).
- (e) Separate institution for alcoholism and drug addiction.
- (f) Boarding-out facilities enlarged for all services.
- (g) Social service for follow-up, prophylaxis, placement, etc.
- (h) Occupational therapy extended to all services.
- (i) Private sanatoria for those wishing such accommodation.
- (j) Education for medical students, graduate physicians, undergraduate and graduate nurses, social workers, occupational therapists, in medical schools and associated hospitals and also school teachers and other persons connected with training of children.
- (k) Psychiatric research.

Mr. Chairman, I would suggest that Dr. Vezina speak next because there are some problems in that province which are not the same as they are in some of the other provinces; and then if after he makes a short presentation you desire to have any questions asked, why, some of those who are present here will be glad to answer them.

The CHAIRMAN: Thank you, Dr. McGhie. Dr. Vezina, will you please come forward?

Dr. L. R. VEZINA, Called.

The CHAIRMAN: Will you proceed, Dr. Vezina?

The WITNESS:

SOCIAL SECURITY

French summary of a memorandum respecting the problem of mental diseases in connection with the health insurance scheme.

Outline of the Memorandum:

1. Introduction.
2. Prevention.
3. Treatment.
4. Cost.
5. Suggestions.
6. Appendix.

1. Introduction

The problem of mental diseases is by far the most important of all hospital problems, both in Canada and abroad. As a matter of fact, in our country 33 out of 100 hospital beds are occupied by sick people admitted to a hospital and treated for mental ailments.

When one considers the cost of hospitalization, one realizes at once the necessity of thoroughly proving the question of mental diseases and deficiencies, were it only for the purpose of reducing the cost in this connection to physically possible proportions.

The progress of science leads us to-day to consider the individual not only in relation to his physical condition and his degree of education, but also in relation to his psychic or mental behaviour.

Thus, regardless of the individual's physical health and degree of education, his mental balance sets him down either as an asset or a liability on society's balance sheet.

The difference between the one and the other reduces itself to a question of adaptation to social environment. The individual is born with a potential X— provided by his procreators. Society in which he will move must take into account his possibilities as well as his deficiencies if one wishes the subject to give his maximum output with a minimum of wear. In other words, just as physical health must be protected and improved, so must mental health be the object of special attention.

Finally, specialists in the matter are generally of but one opinion in rejecting the word insane and replacing it by the more correct expression of mentally deficient. And this for the greatest advantage of the sick person and his relatives, near or distant.

2. Prevention

The program formulated to prevent and decrease the number of cases of mental diseases is set forth very completely in the English report which moreover will probably be translated along with all its particulars. It rests in the

first place on the full co-operation of the family doctor and is completed by the utilization of mental clinics, just as physical health has been considerably improved by the kindly collaboration of the medical profession associated with various clinics that are set up by municipal and provincial health boards.

If we add to this well qualified social workers and an organization that encourages scientific research we are assured of the possession of all the necessary equipment for the difficult work we must perform.

3. *Treatment*

Technicians recommend that the sick persons be, insofar as this is possible, treated at home or in general hospitals. Confinement, strictly speaking, will become imperative by reason of the failure of these two methods.

It is believed that hospitalization in specialized hospitals requires a minimum of four beds per 100,000 of population. There would have to be added a bed and a half if one takes into account cases of mental retardation and the more pronounced types of mental deficiency.

These specialized hospitals must conform to the standards established by the American Psychiatric Association, an international organization which is a recognized authority on the matter.

Alcoholic patients and drug addicts would be treated in a distinct institution under the control of the federal government.

Aged persons suffering from mental ailments would be treated in houses of refuge affiliated with specialized hospitals.

Lastly, it is recommended that a larger number of sick persons be placed in private boarding-houses approved by the proper authorities, this to reduce expenditures of capital.

In California, for instance, twenty-one per cent of the sick people registered in mental diseases hospitals are kept in private families where they lead a more active and normal existence.

4. *The Cost of Hospitalization*

About \$20,000,000 is expended yearly in Canada at the present time for the upkeep of mentally ill patients without taking into account the capital invested in institutions. If free hospitalization is offered to all, technicians are of the opinion that the federal government will have to refund to the province one-quarter of the average cost of hospitalization per patient-day.

Summary

Technicians of almost all provinces have studied this question together in the course of various meetings. They approve the plan suggested to deal fully with the problem of mental diseases.

The application of such a plan by the different provinces in collaboration with the federal government will entail certain adjustments to be effected in accordance with conditions peculiar to each province.

The CHAIRMAN: Thank you, very much, Dr. Vezina.

By Mr. Lalonde:

Q. Before Dr. Vezina leaves I have a question or two to ask him. I understand, Dr. Vezina, that you said in your brief that thirty-three beds out of every one hundred beds in the whole dominion are occupied by people with mental diseases? Those are dominion statistics?—A. Dominion figures.

Q. It does not apply only to the province of Quebec?—A. No, they are dominion figures. The province of Quebec is included in those figures as is any other province.

Q. Secondly, I want to know what are the legal formalities to be complied with when mentally diseased people are seeking entry into a hospital in the

province of Quebec? Are there any legal proceedings to be followed?—A. No, there are no legal proceedings necessary but there are provincial regulations governing admission to mental hospitals.

Q. I am asking you that because the other speaker has said in his brief, if my memory serves me, that there are some legal formalities to be followed.—A. In some cases, but not as a general rule.

Q. In the province of Quebec are there any legal formalities to be followed?—A. There are no legal formalities but once the requirements are met then the individual is under the protection of the law and loses his liberty.

Q. My last question is this: are there in the province of Quebec private institutions taking care of mental diseases?—A. I think there are two private institutions for nervous diseases.

Q. Can you give their names?—A. The sanatorium Prevost in Montreal and the sanatorium Mastai in Quebec.

Q. All other hospitals taking care of mental diseases fall under provincial jurisdiction?—A. Yes.

Hon. Mr. MACKENZIE: I have two or three questions that I would like to ask Dr. McGhie. You mentioned in your brief that there are four beds per one thousand population, and also on the 31st of December, 1940, we had 44,163 patients in mental hospitals?

Dr. McGHIE: Yes.

Hon. Mr. MACKENZIE: What accommodation have we got now of beds in the whole dominion?

Dr. McGHIE: I think it is shown in that brief. The appendix, Mr. Chairman, also gives those figures, thirty-three beds out of a hundred. I might say, Mr. Minister, that this four per thousand beds represents those who are mentally ill only. With the epileptics and mental defectives you need 5 to 5.5 per thousand of the population. On page 19 it is shown that we had 39,441 beds, according to federal statistics, on December 31, 1940, and we had 44,163 patients so our hospitals are 110 per cent filled. We have got patients sleeping on mattresses, on couches, and in corridors and sunrooms that were not originally intended for bed accommodation. That is the situation.

Hon. Mr. MACKENZIE: It is safe to say that you require many more beds to-day?

Dr. McGHIE: I think the figures shown here are 17,000 more beds to meet the situation in Canada as a whole.

Hon. Mr. MACKENZIE: The other question is in regard to these travelling mental clinics. How extensively are they in operation?

Dr. McGHIE: In this province—I cannot speak in detail for all other provinces—at the outbreak of the war when many of our staff went into the armed forces we served about 100 towns and cities. There is one operating from Brockville which spends every Monday afternoon and Tuesday in the Ottawa Civic and other general hospitals in this city. We serve about 100 towns and cities in this province and have examined somewhere between 20,000 and 30,000 persons since they started eight years ago. Alberta has had a travelling clinic for some time, and Nova Scotia more recently have had one clinic and the burden has been accepted by the province as a whole, but the question is to get trained personnel to carry out that work.

Mr. HOWDEN: I was going to say that I think I know what Mr. Lalonde had in his mind when he was asking the witness with regard to legal regulations in connection with having patients attended in mental hospitals. We might as well discuss this matter from a very practical standpoint. I have often been called at home in my work in connection with cases of insanity. We have in Manitoba an asylum at Selkirk and we also have a psychopathic ward at the

Winnipeg General Hospital. They are both jammed, and the only way that we can get any consideration very often with violent cases of insanity is to swear out a warrant in the police station in order to get them taken into the jail first of all and then transferred into the asylum. Personally as a doctor in order to spare the feelings of the family I have had to swear out a warrant for insane people a number of times within recent years in order to have consideration from these institutions. It is not the fault of the institution. The institutions are crowded and, of course, if they cannot and will not give you consideration in any way you can always go to the local police station and swear out a warrant for a man's arrest on insanity and have him taken to the jail and then in the course of two or three days he gets into an institution. I have an idea that is what Mr. Lalonde had in mind.

The CHAIRMAN: Any other questions?

Mr. SHAW: Mr. Chairman, reference was made to scientific research centres, the necessity of having them under such a scheme. I wonder if I might have further information with respect to the number and distribution of scientific research centres dealing with mental research work.

Dr. McGHIE: I would like to call on Dr. C. B. Farrar, Professor of Psychiatry at Toronto where they have such a centre, to answer that question.

Dr. FARRAR: I can only speak from the experience in this one centre which has been organized some five years. A special floor in the hospital was set apart containing twenty beds. This is maintained as a regular part of the hospital but patients are admitted to it not as treatment cases, that is, not as regular service cases. Admission is reserved for patients who are selected because of their research value. Of course, treatment in this particular service is rather secondary to the primary purpose of research. In such a limited centre it is necessary to restrict our problems. So far we have been working mainly on cases of the mental disorder of adolescence commonly known as schizophrenia and particularly the biochemistry of this disorder. Studies of the blood and the various fluids, the electrical reactions of the brain, and so on, are being investigated here and some results are beginning to show which I think will be of value both in the differentiation of this particular form of illness and in its treatment although research problems of this nature are really long range problems and require a good many years to bring completion.

Mr. SHAW: Mr. Chairman, could we acquire any information with respect to the number of such centres in Canada?

Dr. McGHIE: Mr. Chairman, I think in a general way it is safe to say that the places that are most suitable for such investigation are university centres where they have medical schools and even in some schools where they may not, for where there is an educational centre you have a student group and they become interested in these personality problems, and this research can be advanced in these centres. In the medical schools you have all the facilities of the laboratories that are available there. While in Manitoba and in some of the other centres there is some attempt to study particularly some of these problems, there is no special staff set apart for that and they carry that along as part of their work and are over-burdened. That is one of our problems in this field. We want new facts, and the only way to get them is to investigate, and I would suggest that university centres are the proper places to begin.

Mr. FULFORD: Mr. Chairman, I would like to ask Dr. McGhie a question. We know that certain types of insanity are curable. What percentage of those who are admitted to mental hospitals are discharged later as cured, or if not cured, at least able to return and take their place in society?

Dr. McGHIE: I would ask Dr. Stevenson, hospital superintendent formerly in charge of Whitby and now London, to give first-hand information about the discharge rate.

Dr. STEVENSON: The average discharge rate from the Ontario mental hospitals has been between 60 and 65 per cent of those admitted. That does not mean that they are all cured but of those the great majority are able to remain at home. Many of them return to work. About one-third of those who are discharged ultimately return for further treatment in the mental hospital.

Mr. McCANN: Mr. Chairman, I wish to ask Dr. McGhie two or three questions. He made a statement that costs were \$20,000,000 per year for mental care. Is that over and above receipts from private patients? The second question has to do—

The CHAIRMAN: Take each question by itself, please.

Dr. McGHIE: That is the gross cost. Am I right?

Hon. Mr. MACKENZIE: The annual gross cost.

Dr. McGHIE: That is included in one of the tables at the back in the appendix.

Mr. McCANN: And receipts are about one-third?

Dr. McGHIE: In our province, of course, we count as receipts all revenue that comes from the staff, paid by the staff, as well as money that comes in from paying patients. Our costs of operation are something over \$5,000,000 and we get back \$1,300,000 from paying patients and other revenue in the province of Ontario.

Mr. McCANN: With reference to the boarding-out system your statement was to the effect that 3 or 4 per cent of those in institutions are taken care of under the boarding-out system. How do your results compare with reference to improvement and cure of those cases to the cure in institutions and the statement that in California it runs somewhat over 20 per cent? What number who are in institutions are on the boarding-out system? Are climatic conditions there a factor? What I mean by that is under climatic conditions in California these patients are outdoors a great deal more and they are not such a bother to the people who are boarding them as they will be in this country where they are housed anywhere from five to six or more months per year.

Dr. McGHIE: I can speak here chiefly about Ontario. As to the California situation I think the commissioner there in charge of mental hospitals made up his mind he would find out just how large a percentage he could put out in the community. I think climatic conditions enter into it in that they are more easily supervised there than they are on our winter roads. In Ontario this 3 or 4 per cent is a specially selected group, people who have reached a point in their recovery for the most part that we are not ready to send them back on probation because the home situation is not suitable and we place them boarding out. A number of them have returned to the hospital but on the whole they are happier there. It costs us less than if they were in the hospital and the recovery rate is somewhat better, but that is effected by the fact they are chosen as a particular group.

Mr. McCANN: In the case of the older type of patient, the senile type, who come under the Old Age Pension Act, in the event of them being hospitalized, are their pensions payable to the institutions?

Dr. McGHIE: I may say again that there are some institutions—there is one in British Columbia in which they have set apart a separate building on the grounds of the Essondale hospital where these people are not committed as mentally ill although they have mental symptoms and they receive assistance. In the province of Ontario where such an institution has not been set up, once the person is committed to a mental hospital he no longer receives the old age pension and he does not receive it until he is finally discharged from supervision by the mental hospital authorities.

Mr. McCANN: And then they are reinstated?

Dr. McGHIE: Yes, that is true.

Mr. McCANN: I would like to ask a question with reference to the inmates of institutions who are being treated for mental illness as the result of neurosyphilitic conditions: what is the number throughout the country who have that condition? Is it not a fact that if we could entirely eradicate syphilis, both by education and preventive measures and treatment, that the problem of neurosyphilis would cure itself within a term of years?

Dr. McGHIE: I think that as in all psychiatric problems preventive measures are important among all these people, and that is particularly true where you have a specific treatment as in the case of syphilis. The percentage is not as high as we would expect because of the treatment in effect—I think it has not reached 5 per cent of the total, but when you have 45,000 that makes a large group, and with adequate treatment there has been a great change in the last twenty-five years in that percentage. Your statement that we should be able to prevent the admission of people for that condition should be possible with medical treatment in the early stages of the disease.

Mr. MACINNIS: I would like to ask Dr. McGhie if there are statistics as to the cause of mental illness, and whether there are any statistics as to the cause of the percentage of mental cases that are attributable to the mental condition of parents?

Dr. McGHIE: I will ask Dr. Cathcart to reply.

Dr. CATHCART: That is a very difficult question to answer. Of course, we cannot overlook the effects of heredity in relation to mental disease, but our efforts in exploring the causes have latterly tended to play down that field, partly on account of the fact that for the moment we cannot do very much about it, but really because there is a richer field in another direction. I think, probably, to illustrate one of my points I might mention a body of information that happens to be within my particular province. We have yet to have a single case of psychosis from aircrew overseas. Now, these are men who are, of course, near the front of battle; there cannot be any doubt of that; and yet we have not yet had a single case back from overseas. We may stop to analyse that. Undoubtedly, there are many of those men who, we might say, had poor heredity—perhaps a smaller proportion than other groups—but I have certain explanations that come to my mind. I may say that there are four that immediately came to my mind: these young fellows, before they go up for enlistment, have fought a little battle with themselves and they are fairly well adjusted. It is a risky game. They are well aware of that, and they know the risks will start within three or four months. They do not decide that overnight. Then they have a little battle with their parents, because while their parents may be quite proud of their decision they are, nevertheless, apprehensive about it, and they have to have a sufficient understanding with their parents to put that story across. Then there is the academic standing—the academic requirements—that is they were up until eight or nine months ago—these were all men who had passed their academic hurdles—the entrance examination and the junior matriculation. I speak of hurdles because I find upon inquiry into the history of many of my ordinary clients that they turned aside at those hurdles for one reason or another. They do not go through with those things. Others, of course, do not reach that standard. There is a rich field of study there in that large group that leave school in the grades. I think it is probably not quite fully understood how much importance there is in relation to the early academic teaching. I am inclined to put a considerable value on that—much more than we might ordinarily mention in relation to the causes of mental disease, or because of difficulties of that nature in later life. So many of our psychiatric problems of adult life are what we speak of as situation; they arise out of difficulties in the immediate environment but difficulties to which they have been sort of sensitized to in their childhood

and difficulties which might have been obviated had they had better training both emotionally and academically. Therefore, I think that is a very important field. I believe the school is a very important field for the prevention of disease, through the teaching of mental hygiene, because that population is more readily appreciable than is the adult population and probably more easily impressed.

The CHAIRMAN: Dr. McGhie, we are very grateful to you and your colleagues for coming here this morning and giving us this evidence.

Mr. KINLEY: May I ask one question, Mr. Chairman. To what extent is the care of the insane in Canada primarily still a municipal obligation?

Dr. MCGHIE: I am afraid I cannot answer that question in detail. I do know that they have people in charge of this in the three maritime provinces who are at present discussing the problems—I do know that in Nova Scotia they have in the county institutions certain chronic types of mental illness and certain borderline types, and they take into their provincial institutions those that are acutely disturbed, and they use the county or municipal home as a type of hospital to care for a group of patients who are not acutely disturbed. Outside of that, I think for the most part they have the acute cases in mental hospitals, and in those provinces also they send out to the county homes the patient who is a chronic case and is not showing acute symptoms, as a means of clearing beds for the more acutely disturbed.

Mr. KINLEY: You refer to what are known as the harmless insane; they go to the provincial home, but the municipality must pay for the patients that go to the provincial institutions, although, perhaps, not enough to sustain the institution; but there is a charge on the municipality?

Dr. MCGHIE: It amounts to about 10 cents a day per patient and is taken from the railway tax in this province.

Dr. GREGOIRE: In Quebec the local municipalities have got to contribute half of the hospital costs on a fifty-fifty basis with the provincial government.

Mr. HOWDEN: Not only for mental sickness but for all sickness.

The CHAIRMAN: Dr. McGhie, you will be available later to the committee if we require your attendance?

Dr. MCGHIE: Yes, Mr. Chairman.

The CHAIRMAN: On behalf of the committee I wish to thank you and your colleagues for your attendance here to-day. We are grateful to you all.

Now, gentlemen, we have representatives from the Trades and Labour Congress of Canada with us, and I shall ask Mr. P. R. Bengough to come forward.

Mr. P. R. BENGOUGH, representing The Trades and Labour Congress of Canada, Called.

By the Chairman:

Q. Mr. Bengough, you are the president or the acting president of the Trades and Labour Congress of Canada, and you are accompanied by Mr. J. A. Sullivan, the vice-president, and Mr. Arthur Henning, the secretary?—A. Yes.

Q. Will you proceed, Mr. Bengough?—A. Mr. Chairman and members of the committee:—The executive council of The Trades and Labour Congress of Canada has considered the draft bill on health insurance as contained in the department proposals of a plan for national contributory health insurance, public health, the conservation of health, the prevention of disease and other matters related thereto.

The Trades and Labour Congress of Canada on whose behalf we appear is an organization representing fifty-eight international unions with 1,518 Canadian locals; ten national unions with 164 locals; three provincial federations of

labour; forty-one Trades and Labour councils situated in the various cities throughout this dominion; 124 directly chartered and affiliated federal unions; representing a total of 1,849 local unions with a combined membership of 264,375. This Trades and Labour Congress of Canada was organized in the city of Toronto on the 26th day of December, 1883, and for almost sixty years has been seeking and securing legislation of benefit to the workers and the citizens of Canada and for the last twenty-five years has consistently been pressing for a scheme of national health insurance.

As stated, we have asked for a national scheme. Our reasons for this request is in conformity with our general desire for uniform legislation throughout Canada. The need for uniformity becomes even greater in a scheme for health insurance framed to improve the health of the people. It is quite apparent that if some provinces introduced health insurance plans for their citizens, while others did not, the movement of people from one province to another would tend to break down the health standards that the other provinces had established.

As Canadians we desire the maximum health standards for all citizens in Canada. We understand the dominion government has taken this matter under advisement, but recognizing that provincial governments are reluctant to surrender control over fields of activity now recognized as being within their jurisdiction, the dominion government has taken the alternative of extending assistance to the provincial governments for the setting up of health insurance providing the provinces conform to certain standards. In view of this, we concur in the principles contained in the proposed Dominion Act of making dominion grants-in-aid to the provinces for public Health Insurance Acts.

Before leaving this, however, we would like to point out that with unemployment insurance in effect, there is need for a closer tie-up between unemployment insurance benefits and sick benefits. We think that any scheme of health insurance should include cash benefits to take care of the time lost on account of illness and we do see difficulty in such provision being included in the present bill.

We are fully in accord with the principle of complete coverage as outlined. Organized labour is heartily in favour of medical care being available to all citizens, men, women and children, in the community, and approves the effort made in this direction in the draft bill.

We are in accord with the medical, dental, pharmaceutical, hospital and nursing benefits as outlined but would suggest that chiropractic treatment also be given recognition in the bill.

Regarding section 16, covering the establishment of the personnel of the National Council on Health Insurance, we could not possibly agree with the provision that is made for the preponderance of representation of the medical practitioners together with the representation given to other professional groups. The proposals made would place the representation from labour in a minority category, in spite of the fact that they represent the largest body of contributors and as the group providing a substantial portion of the funds, we would certainly insist on having far more control in the administration and the spending of the money than we would have under such a suggested board.

Organized labour itself, has, of course, at all times asked for representation on all boards. We are naturally prepared to concede to the medical profession the right to representation but we could not possibly agree to them having entire control. In our opinion those who provide the funds, namely, the government, employees and employers, should control the national council in the matter of representation.

Labour needs to be assured that the primary purpose of a Health Insurance Act is to operate for the benefit of the contributors and not entirely in the interests of the medical profession.

Second schedule, section 4, in the draft bill for a provincial Health Insurance Act: In dealing with this, we must point out that no information is contained in the proposed bill as to what amount the contributions from labour would be, and so it is impossible for us to commit ourselves on this question, as one can hardly state that they are in favour or against, without knowing the actual cost.

We desire to have the collection system clearly set out so as to know just how much the workers at different rates of wages will be required to contribute for themselves and how much for their dependents; how much the employers will contribute and how much the provincial and dominion governments will contribute. This information is not contained in the draft bill.

In addition we desire to know the general distribution of the cost. That is, what percentage of the total cost would be paid by the employees, what percentage by the employers, and what percentage by the provincial and dominion governments, and again, until such time as we have this information, it is absolutely impossible to express an opinion.

Hospital Benefit, section 31 (1) (i) which reads as follows:

"That any qualified person in receipt of treatment as aforesaid, except as described in paragraph (h) of this subsection, shall be available for clinical observation by the teaching staff of medical schools, etc."

This we could not possibly agree to. A scheme of health insurance on a contributory basis does not mean that one in receipt of benefits automatically becomes a guinea pig for observation. This is a matter for the patient to decide. The inclusion of such provision in our opinion shows a wrong attitude and wrong approach to the whole idea of health insurance.

Section 35 (2), Administration by Commission: This requires that the chairman of the provincial health insurance commission shall be a doctor of medicine. Here again we find efforts being made, in view of the fact that the chairman of the commission is the one member of the commission on a full time basis, to place the entire control of the Act in the hands of the medical association and we cannot agree with this.

Section 35 (paragraph 4) shows how the other members of the provincial commission shall be determined for appointment, and again we find the contributors' position inferior so far as representation is concerned, the emphasis being placed on representation from the professions. We would want considerably stronger representation from labour than is now suggested.

Section 40 (2) relative to the filling of positions requiring professional training and experience: While many sections of organized labour have advocated the advantages of closed shop agreements, we are of the opinion that this is carrying the principle a little too far and is a little lop-sided in view of all the circumstances because no similar provision is made for consultations with representative organizations of employees relative to the employment of their membership outside of those in the professions enumerated.

In part 3 of schedule (c) in which is required an itemized return giving information regarding personnel, livestock, implements, tools and equipment, ships, boats, nets, etc., household furniture, library, mortgages, bonds, stocks and other investments, cash on hand and on deposit, amounts receivable, surrender value of insurance policies and all other personal property together with a statement of amount owing. Frankly, we don't understand the need of this. If it is a health insurance scheme on a contributory basis, then we think the contributor is entitled to receive the benefits without any need of such an investigation.

We are forced to the opinion that the proposed provincial bill is, in effect, a complete closed shop agreement between the governments and the union of medical practitioners, not only covering the employment and salaries to be

arranged by them, but full autonomy in hiring and firing, including administration, and all that it implies in giving full discretion to the membership of the medical association in the giving or withholding of benefits to the citizens who are providing the funds. Frankly, we cannot agree.

In conclusion we would respectfully recommend that in this regard the Act be entirely reconstituted to take control away from the medical profession and place it in the hands of the contributors. We earnestly desire that health insurance be inaugurated as early as possible, but it is important that any measure that might be enacted must primarily be framed so that first consideration is given to protecting the interests of the great mass of those whose health it is designed to protect, and that the interests of others who are to be employed to render the necessary services under the Act must be of secondary importance.

The CHAIRMAN: Mr. Sullivan, do you care to add anything?

Mr. SULLIVAN: No, sir.

By Mr. Wright:

Q. Mr. Bengough, under the proposed Act it is left to the provinces to state whether there shall be a maximum over which the people will not benefit; is it the opinion of the labour congress that that is good?—A. No, we are not in favour of a ceiling on the amount of salaries. Frankly, we believe that all citizens should be included in the health insurance scheme.

By Mr. Wood:

Q. With regard to the last paragraph, “. . . we would respectfully recommend that in this regard the Act be entirely reconstituted to take control away from the medical profession and place it in the hands of the contributors. . . .” would the union of agricultural implement workers be prepared to vest in the farmers, the users of their implements, the same right to control their union?—A. Well, it is hardly the same. After all, the union or implement makers would not be dealing with the farmers, they would be dealing with the employers, and they would ask for representation, but they would not ask for the entire management of the concern, and so there is a difference. In this case the employees are asking for the entire management.

Mr. MAYBANK: I think the employers ought to get some show.

By Mr. Howden:

Q. I would like to ask the witness whether he agrees with anything in this bill at all?—A. Yes, we have stated that we do. We agree with the principle of the dominion government making a grant in aid of the provinces; we agree with the coverage as set out, which are the main parts of the bill; we agree with the benefits that are to be—the inclusion of what is set out in the bill: so we would agree with the whole of it—the whole principle of it; the only thing that we take exception to is the management.

By Mr. Kinley:

Q. Do you agree to joint contribution?—A. Certainly we agree to joint contribution; we think it should be on a three-way basis; that is government, employers, and employees.

By Hon. Mr. Bruce:

Q. I should like to ask the witness if he seriously thinks this Act is being operated for the benefit of the medical profession?—A. Not yet, it is not, doctor, but if it was operated on this basis I would be rather afraid it would be.

Q. Do you think this Act could be operated at all without the medical profession?—A. Well, naturally their services are needed.

Mr. McCANN: Let the chiropractors and labour run it.

By Mr. McGarry:

Q. From what group would you suggest the chairman should be selected, if not the medical profession?—A. Take our compensation boards, which have operated very effectively; many of them have not a medical practitioner in their set-up. We have lawyers, we have representatives from the employers, the chairman representing the government, and we have employers' and employees' representation, people who are providing the fees.

By Mr. Donnelly:

Q. I should like to ask the witness this question: section 31 (1) (i) says: "That any qualified person in receipt of treatment as aforesaid, except as described in paragraph (h) of this subsection, shall be available for clinical observation by the teaching staff of medical schools and hospitals for the better instruction of students in medicine and nursing pursuant to regulations and arrangements made in that behalf—" How long do you think the medical profession would last without being able to observe patients in hospitals? Where would you get your doctors from if they were not allowed to do that?—A. I think I agree it is quite necessary, but that is not the part that we are disagreeing with; that is the portion of the Act which states that it is permissible, or would be recognized, for a beneficiary under the Act to pay the difference between public ward and private ward costs; but if they remain in the public ward then they become automatically subject to observation. It is not that we agree with what is being done, we agree with the fact that it is just because they happen to be in a private ward they are not consulted as to whether they should be under observation or not.

The CHAIRMAN: Public—

The WITNESS: Public ward patient.

By Mr. Donnelly:

Q. Your objection is to the one in the public ward not being consulted?—A. I think so, yes.

Q. If your suggestion is adopted you are going to have a nice mess.

By Hon. Mr. Bruce:

Q. I wonder where the speaker thinks we ever got these doctors from. What future would the profession have if the position he sets forth obtained. There would be no medical profession at all in forty years.—A. Why not?

Q. There would be no patients to secure information from which would assist them to give better service to the public in the future. We simply would destroy the opportunity that we have of gaining medical attention for everybody in the years to come.—A. Well, there is a considerable amount of research which has come out of our universities, possibly the most of it, and these research men are employees of the state.

Q. I did not get that.

By Mr. Fauteux:

Q. Who are the employees of the state?—A. Those who are doing good work in research fields. Quite a lot of medical advance has come out of our universities, employees of the government.

By Hon. Mr. Bruce:

Q. It does not come out of the universities without the assistance of the patients; they are a necessary part of any research work. I am afraid you have complicated it very much.

By Mrs. Casselman:

Q. I should like to say that I think 90 per cent of the patients, private or public ward patients, would be quite willing for their case to be examined by the medical profession. I do not think there would be any fear from the patient's point of view. The number of patients who would object I think would be very small, either private or public ward patients.

MR. MAYBANK: Mr. Chairman, I do not suppose this is the time for argument, but I should like to ask this question of the speaker.

By Mr. Maybank:

Q. Would it be right for me to say this: I fancy the way the conversation has gone so far a good many of the members of the committee and Mr. Bengough feel that there is much greater diversion of opinion than in fact there is, possibly due to some of the wording of the brief—I do not know. I do not see that the medical men on the committee need to feel that labour is very far away from them, as this conversation so far has indicated. Now the question which I wish to direct relates to the sentence at the end of paragraph 2 on page 2. The sentence reads as follows: "We think that any scheme of health insurance should include cash benefits to take care of the time lost on account of illness and we do see difficulty in such provision being included in the present bill." Now, am I to understand from that that the speaker is just expressing a desire as to something the organization would like to see in the future but that there is no real urging for it in this bill nor collateral legislation at the present time, but it is felt they would have to by-pass that for the time being; is that the attitude which they take for the time being in the hope that they will see it some time in the future?—A. I would say yes.

Q. It is not the present urge?—A. There is our difficulty of bringing it into the bill as it is now. We do not want it to be held up on that account.

MR. MACINNIS: I should like to say what I think the witness is getting at is the implication in this section referred to; that is section 31 (1) (i), which reads as follows: "That any qualified person in receipt of treatment as aforesaid, except as described in paragraph (h) of this subsection, shall be available for clinical observation by the teaching staff of medical schools and hospitals for the better instruction of students in medicine and nursing pursuant to regulations and arrangements made in that behalf." Well, every patient is available for the clinical observation of his doctor, but he is not available for the clinical observation of the whole school, and I think the point was very well put, that they object to making the patient, because he happens to be in a public ward, a guinea pig to experiment on; and that is the implication in the section.

HON. MR. BRUCE: Mr. Chairman, I should like to ask the speaker to change that word. It is not for experimentation at all. The patient must be examined to determine the clinical symptoms of disease. The doctor must have the opportunity of doing that. Theory is not sufficient to make a good practitioner; he must have practical experience at the bedside.

MR. MACINNIS: That is quite true, and every doctor, I assume, gets that as he treats his patients. That is the way he gets experience.

MR. McCANN: Where does he get the teaching?

MR. DONNELLY: Where does he get the experience?

MR. MACINNIS: From the patient.

MR. DONNELLY: At the hospital.

MR. MACINNIS: Every time I go to a doctor or you get a doctor the doctor gets experience from observing the patient.

MR. DONNELLY: Your theory is if he does not get the experience in college he starts out and gets the experience in the country.

Mr. MACINNIS: Quite true it does not say just because the patient happens to be in a public ward instead of a private ward that he is a fit subject for the doctors to observe and to experiment with.

Hon. Mr. BRUCE: It is not experiment; it is to get experience.

Mr. MACINNIS: How do they get experience except by experiment?

The CHAIRMAN: We must not get off the beam in a discussion on hospital or university practice. We can get that when we come to section 31, when the section is being discussed. Discussion of this kind, in my opinion, is out of order at this time.

By Mr. McGregor:

Q. Does your organization agree that unemployment insurance should be payable by everybody or should remain just the way it is?—A. We prefer it without any salary limitation at all; include all.

Q. Everybody?—A. Yes.

Mr. HOWDEN: I should like to say this, Mr. Chairman, that this matter hits at the very centre of the whole life of medical science. There is no doubt about it that we learn from practical demonstration, it does not matter whether you are a musician, a machinist, a medical man, or anything else; we learn by practical demonstration. We learn our profession by being taken by a man who knows his business and shown certain things with regard to medicine. If we have health insurance it means that the people of Canada will come under the health bill, and if we adopt the suggestion of the witness it means the exclusion of all students from the bedsides where they learn their business. I think it is impossible. The very idea is quite out of the question.

Mr. FULFORD: I agree with Mrs. Casselman. I know absolutely that the medical student must have his bedside experience. I think that the average person would object if he were told that he had to submit to examination by a large group of students, but if he were asked to do it I am sure that at least 90 per cent would allow doctors and others to observe his condition.

The CHAIRMAN: I think Mr. Maybank is quite right when he says there is a wide diversity of opinion which might be deferred until we are discussing the section.

By Mr. Kinley:

Q. This is what the section says: "That any qualified person in receipt of treatment as aforesaid, except as described in paragraph (h) of this subsection, shall be available for clinical observation by the teaching staff of medical schools and hospitals," and so on. Who are the exceptions? There are exceptions now?—A. The exceptions are those who are able to pay; there is a difference between the public ward and the semi-private or private ward patients.

Q. What you object to is making the others obligatory?—A. Yes, sir.

Q. You do not care if they want to do it voluntarily?—A. No; I think they would.

The CHAIRMAN: We are very grateful, Mr. Bengough, for your presentation. I assure you when the section is discussed your brief will be given consideration.

I should like to announce that on Tuesday of next week we hope to have Sir William Beveridge address the committee at 11 o'clock.

We shall adjourn now until Friday at 11 o'clock, when we will discuss public health.

The Committee adjourned at 12.40 to meet on Friday, May 21, at 11 o'clock a.m.

APPENDIX "A"

(1) TABLE OF BED CAPACITIES OF HOSPITALS IN CANADA, JANUARY 1, 1940

<i>Type of Institution</i>	<i>Number of Beds</i>	<i>Percentage of Beds</i>
<i>Public</i>		
General	46,344	39.0
Women's	1,019	0.9
Children's	1,293	1.1
Isolation	1,437	1.2
Convalescent	887	0.7
Red Cross	621	0.5
Incurable	3,094	2.6
Not Classified	2,774	2.3
<i>Private</i>	3,915	3.3
<i>Special</i>		
Dominion	9,436	7.9
Mental	39,277	33.0
Tuberculosis	8,873	7.5
Total	118,970	100.0

The bed occupancy of Public General Hospitals is approximately 60 to 70 per cent, that for tuberculosis sanatoria 90 per cent and for mental hospitals over 110 per cent. Thus, in comparing the amount of hospitalization of mental patients with others, the figure of 33.0 per cent shown in the table, gives too low an estimate. The actual number of mental patients hospitalized is probably nearer one-half than one-third of all hospital patients.

MINIMUM STANDARDS FOR THE OPERATION OF MENTAL HOSPITALS SET UP BY THE AMERICAN PSYCHIATRIC ASSOCIATION IN 1925 AND RE-AFFIRMED FROM TIME TO TIME SINCE THEN.

1. The chief executive officer must be a well-qualified physician and experienced psychiatrist whose appointment and removal shall not be controlled by partisan politics.
2. All other persons employed at the institution ought to be subordinate to him and subject to removal by him if they fail to discharge their duties properly.
3. The positions and administrations of the institution must be free from control for the purposes of partisan politics.
4. There must be an adequate medical staff of well-qualified physicians, the proportion to total patients to be not less than 1 to 150 in addition to the superintendent, and to the number of patients admitted annually not less than 1 to 40. There must be one or more full-time dentists.
5. There must be a staff of consulting specialists at least in internal medicine, general medicine, general surgery, organic neurology, diseases of the eye, ear and throat, and radiology, employed under such terms as will ensure adequate services.

6. The medical staff must be organized, the services well defined and the clinical work under the direction of a staff leader or clinical director.
7. Each medical service must be provided with an office and an examining room, containing suitable conveniences and equipment for the work to be performed, and with such clerical help specially assigned to the service as may be required for the keeping of the medical and administrative records.
8. There must be carefully kept clinical histories of all the patients, in proper files for ready reference on each service.
9. Statistical data relating to each patient must be recorded in accordance with the standard system adopted by the Association.
10. The patients must be classified in accordance with their mental and physical condition, with adequate provision for the special requirements for the study and treatment of the cases in each class, and the hospital must not be so crowded as to prevent adequate classification and treatment.
11. The classification must include a separate reception and intensive study and treatment department or building, a special unit for acute physical illnesses and surgical conditions, and separate units for the tuberculosis, and the infirm and bedfast.
12. The hospital must be provided with a clinical and pathological laboratory, equipped and manned in accordance with the minimum standards recommended by the Committee on Pathological Investigation.
13. The hospital must be provided with adequate X-ray equipment and employ a well qualified radiologist.
14. There must be a working medical library and journal file.
15. The treatment facilities and equipment must include:
 - (a) A fully equipped surgical operating room.
 - (b) A dental office supplied with modern dental equipment.
 - (c) Tubs and other essential equipment for hydrotherapy operated by one or more specially trained physiotherapists.
 - (d) Adequately equipped examination rooms for the specialists in medicine and surgery required by the schedule.
 - (e) Provision for treatment by physical exercises and games and the employment of specially trained instructors.
 - (f) Adequate provision for recreation and social entertainment.
16. Regular staff conferences must be held at least twice a week where the work of the physicians and the examination and treatment of the patients will be carefully reviewed. Minutes of the conference must be kept.
17. There must be one or more out-patient clinics conducted by the hospital in addition to any on the hospital premises. An adequate force of trained social workers must be employed.
18. There must be an adequate nursing force, in the proportion of total patients of not less than 1 to 8, and to the patients of intensive treatment and acute sick and surgical units of not less than 1 to 4. Provision must be made for adequate systematic instruction and training of the members of the nursing force.
19. Mechanical restraint and seclusion, if used at all, must be under strict regulations and a system of control and record by the physicians, and must be limited to the most urgent conditions.

Reference:

Medical Journal of Psychiatry, September, 1933, pages 423-425 incl.
 In the report of the Psychiatric Standards and Policies Committee of the American Psychiatric Association published in the American Journal of Psychiatry 1940, Vol. 97, page 462, minor changes in the schedule were proposed.

(3) NUMBER OF BEDS AND NUMBER OF PATIENTS IN MENTAL HOSPITALS
 COMPARED WITH NUMBER OF PERSONS IN GENERAL POPULATION
 DECEMBER 31, 1940

	Number	Number per thousand of general population
Beds	39,441	3.45
Resident Patients . . .	44,163	3.87
General Population . . .	11,422,000	1,000.00

Since these figures for patients include defectives and epileptics, the number per 1,000 should be from 5.0 to 5.5, that is to say, 4.0 for the mentally disordered and 1.0 to 1.5 for the mentally defective and epileptic. To reach the proportion of 5.0 per 1,000 for beds would require the addition of more than 17,000.

(4) FIRST ADMISSIONS TO MENTAL HOSPITALS OF PERSONS OVER 60 YEARS OF AGE

	Number	Number over age of 60	Percent. over age of 60
Canada, 1940 . .	6,989	1,324	19.0
Ontario, 1940-41	2,304	499	22.6

(5) MENTAL HOSPITAL GROSS EXPENDITURES

Province	Gross Expenditure	Patient Maintenance Revenue	Percent. Recovered	Proportion Recovered
Ontario, 1942-3 . .	\$ 5,600,000	\$1,230,000	22.1	1/4.5
Manitoba, 1942-3	977,000	186,000	19.0	1/5.2
Sask., 1942-3† . .	1,700,000	125,000	7.4	1/13.6
Canada, 1940* . .	\$19,543,000	\$2,061,000	10.5	1/9.5
(Proposed grant from Federal Government)			11.1	1/9.0

† Estimated.

* This figure, supplied by the Dominion Bureau of Statistics, 1940 report, includes Federal hospitals.

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Canada Social Security, 1943

SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 12

FRIDAY, MAY 21, 1943

WITNESSES:

- Dr. Adelard Groulx, Director of Public Health of the City of Montreal, and President, Canadian Public Health Association;
- Dr. Robert D. Defries, Director, School of Hygiene, and Connaught Laboratories, Toronto; and
- Dr. John T. Phair, Chief Medical Officer, Provincial Department of Health, Toronto, Ont., and Honourary Secretary, Canadian Public Health Association.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

FRIDAY, May 21, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. In the absence of Hon. Cyrus Macmillan, the Chairman, Mr. J. A. Blanchette, the Vice-Chairman, presided.

The following members were present:—Messrs. Blanchette, Bourget, Casselman (*Mrs.*), Cleaver, Donnelly, Fauteux, Fulford, Gershaw, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Leclerc, MacInnis, MacKinnon (*Kootenay East*), McCann, McGarry, McIlraith, Shaw, Veniot, Wood and Wright.—22.

Dr. Adelard Groulx, Director of Public Health of the city of Montreal, and President of the Canadian Public Health Association, was called. He introduced the following representatives of the Canadian Public Health Association:—

Dr. John T. Phair, Chief Medical Officer, Provincial Department of Health, Ontario, and Honorary Secretary of the Association;

Dr. G. F. Jackson, Medical Health Officer of the city of Toronto;

Dr. F. Ladouceur, Medical Officer of Health, Casselman, Ont.

Dr. Robert D. Defries, Director, School of Hygiene, and Connaught Laboratories, Toronto.

Dr. Defries presented a brief on behalf of the Canadian Public Health Association.

Dr. Groulx presented a summary of the Associations' recommendations.

Dr. Defries, Dr. Groulx and Dr. Phair were examined by the Committee.

On motion of Dr. Hurtubise it was agreed that the Tables attached to Dr. Defries' brief be printed as Appendix "A" to this day's evidence.

The Chairman thanked the witnesses, who then retired.

The Committee adjourned at 12.40 p.m. to meet again Tuesday, May 25, at 11 o'clock a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

May 21, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. The Deputy Chairman, Mr. J. A. Blanchette, presided.

The DEPUTY CHAIRMAN: Order, please; owing to the inability of the regular chairman to be with us this morning I have been asked to preside at this meeting. We are to have this morning a submission given to us under the auspices of the Canadian Public Health Association. The brief is to be presented by Dr. R. D. Defries. I would like to ask Dr. Adelard Groulx, who is Director of Public Health of the city of Montreal and President of the Canadian Public Health Association, to introduce his colleagues to us and afterwards introduce the speaker, Dr. Defries.

Dr. GROULX: Mr. Chairman, members of the Special Committee on Social Security; I have the honour this morning to introduce to you the gentlemen who are with me to-day and who are members of a special health insurance committee of the Canadian Public Health Association. They are Dr. R. D. Defries, Director of the School of Hygiene and the Connaught Laboratories of the University of Toronto; Dr. John T. Phair, Chief Medical Officer of the Department of Health of Ontario and Honorary Secretary of the Canadian Public Health Association; Dr. Gordon Jackson, Medical Officer of Health of the city of Toronto, and Dr. F. Ladouceur, Health Officer of Casselman, Ont. On behalf of my colleagues and myself I would like to assure your committee that we appreciate very much the opportunity of being here to-day to present to you on behalf of the Canadian Public Health Association a brief of our views on the very important question of health services and insurance in Canada. This brief has been prepared by our committee and will be presented and read to you, as the chairman said, by Dr. Defries. With your permission may I call on Dr. Defries.

Dr. R. D. DEFRIES, called.

The WITNESS: Mr. Chairman, Mrs. Casselman, and gentlemen:—

THE CANADIAN PUBLIC HEALTH ASSOCIATION—ITS ORGANIZATION AND PURPOSES

The Canadian Public Health Association was organized under dominion charter in 1912 and is a professional society, representing those who are rendering public health service through official departments or voluntary agencies. Its membership includes physicians serving as medical officers of health throughout Canada, members of the dental, nursing and engineering professions, and other professionally trained personnel serving in this field. In the thirty years of its work, the outstanding leaders of public health have served as its officers. It therefore presumes to speak for those who are most familiar with the actual conduct of public health services throughout Canada.

The Canadian Public Health Association has consistently stressed the need for health insurance, and reaffirmed its advocacy of a national plan in the following resolution which was adopted at the association's thirty-first annual meeting in Toronto in June, 1942:—

Whereas there is urgent need in Canada for the more adequate provision of general medical, dental, and nursing service,

And experience in Great Britain and other countries has demonstrated the value of a system of compulsory, contributory health insurance,

And this association believes that in any health insurance programme adequate provision for preventive services is essential,

Be it resolved that this association endorses the principle of national health insurance and urges that the provision of preventive services should form an essential part of this programme.

THE PURPOSE OF THIS SUBMISSION

The purpose of this submission is to show:—

1. That preventive medical services are essential to the success of health insurance.
2. That all parts of Canada must have adequate local health services.
3. That the practising physician should provide both preventive and treatment services; and that, to render these services, he must have assistance from an adequate local department of health.
4. That adequate local health department services depend on provincial departments of health for direction and for financial assistance.
5. That grants-in-aid from the federal government offer the solution of meeting urgent public health problems, particularly the control of tuberculosis, treatment of mental illness, and control of venereal disease, and the development of adequate local health department services to cover all parts of Canada.
6. That it is essential that health insurance and public health be integrated both in provincial and local administration.
7. That qualified public health personnel are required in the conduct of public health work and provision for assisting in their training is necessary.
8. That more adequate support of medical research in Canada is essential to the progress of medicine and the success of health insurance.

1.

THE INCLUSION OF PREVENTIVE MEDICAL SERVICES IS ESSENTIAL IN AN ADEQUATE PLAN OF HEALTH INSURANCE

The term "health insurance" implies provision for maintaining and promoting health. Unfortunately, health insurance measures in effect in various countries have related almost exclusively to the treatment of sick persons and the provision of assistance while they are unable to work. Obviously this type of service is merely provision for medical care and sick benefits—*sickness insurance*, and not health insurance. Unless due provision is made for the inclusion of adequate preventive services, the term "health insurance" is an obvious misnomer. The success of health insurance depends, therefore, on the inclusion of public health and preventive medicine.

The failure to distinguish between health insurance and sickness insurance is not surprising, since public health services and preventive medicine are developments of the past few decades. The conception that, in addition to providing treatment in case of sickness, physicians should supervise the health of families under their care has been growing in recent years, and many physicians now consider this to be part of their obligation to the family. The preventive aspects of dentistry have been accepted for some time and are appreciated by the public as a result of the widespread attention drawn by the dental profession to the importance of such care.

It is illogical to allow preventable diseases to continue to occur and then have to provide for all the costs and suffering associated with treatment. All diseases and conditions which result in disability or death, and which may in part at least be prevented, should be vigorously attacked in order to reduce their incidence to a minimum. Medical science has enabled great advances to be made in the prevention of certain diseases and has provided essential information in regard to the fundamental requirements for the maintenance of health. Broadly speaking, the large group for which prevention is possible consists of all communicable diseases, diseases due to faulty nutrition, diseases arising out of occupations with definite health hazards, and illnesses and disabilities associated with maternity. Prevention results in the saving of many lives, as well as in reducing the extent of sickness and disability. The whole of the "safety first" movement is a recognition of the necessity of reducing preventable disabilities and deaths from accidents.

Much has been accomplished through the adoption of preventive measures by organized departments of health, practising physicians, nurses, and dentists; and in this work the voluntary health agencies have made important contributions. Such results as the reduction in the death rate of tuberculosis in Ontario to less than one-fifth the rate of 1900, of typhoid fever to one fiftieth the rate of 1900, and of diphtheria to one eighty-fifth of the 1900 rate, are illustrations of what has been accomplished. There has been a marked reduction, too, in the number of infants dying in the first year of life, so that the infant mortality rate for the whole of Canada has fallen from 93 per thousand living births in 1936 to 60 in 1940. These great reductions in the number of deaths of infants and young children have resulted in an increase in the life expectancy. In the United States the life expectancy in 1900 was 49.2 years and this has risen to 63.7 years in 1942, representing an increase of 13½ years. Canadian data indicate a similar increase in life expectancy. As stated the increase in life expectancy is due primarily to the great reductions in the numbers of deaths in infants and young children. Gratifying as are these reductions in sickness and deaths, much remains to be done. In Canada in 1941 there still were recorded 6,072 deaths from tuberculosis (all forms), 165 deaths from typhoid fever, and 240 deaths from diphtheria. Each of these diseases is preventable and every case results in the needless exposure of other members of the community.

Prevention is Cheaper than Treatment

Preventive services cost much less than treatment services. A study was made of the cost of diphtheria in Ontario for a year when diphtheria was very prevalent before prevention was possible through immunization with diphtheria toxoid. In 1924, 3,073 cases were reported, with 322 deaths. Costs of hospital care in various cities for the treatment of some of these cases, together with an estimate of the cost of medical care at home, amounted to \$300,000. In contrast, the cost of giving the preventive treatment of diphtheria toxoid to *ALL the pre-school and school children in the province* would have been but a third of this amount. When it is remembered that such immunization does not have to be repeated yearly, but only a "reinforcing" dose is required a few years later, the significance of the difference in the cost of treatment and preventive services is appreciated. If an estimate of the actual cost to Ontario were made, it would have to include the estimated economic value of the 322 children and young adults who died, together with other costs. Such an estimate would represent several millions of dollars. In Ontario in 1941 the cost of treatment of 6,666 patients in tuberculosis sanatoria amounted to \$2,794,935. Only a fraction of this amount is spent in the discovery and examination of contacts, tuberculin testing, and mass X-ray examination, all of which form an essential part of the control program.

In such instances as the loss of life from diphtheria, tuberculosis, and typhoid fever, the results and shortcomings are comparatively easy to assess. In other instances, where the application of preventive measures is less direct, much

may still be achieved. For example, an important cause of death in persons under fifty is rheumatic heart disease. According to recent surveys, more deaths in persons under 20 years are due to this cause than to pulmonary tuberculosis. Rheumatic heart disease is a disease which is characterized by repeated attacks over a period of years. It is generally agreed that a large proportion of the disability and deaths can be prevented by adequate supervision of persons who have already had one attack. Although this requires the provision of sufficient hospital beds and other facilities, the most important factors are the early recognition of cases, and the close and prolonged supervision of individual patients which can best be done by the physician in private practice who is the first and often the only one who is aware of the condition. The importance of efforts in rheumatic fever lies in the fact that it is one of the chief causes of heart disease in later adult life, and if the incidence and mortality of heart disease are to be reduced, attention must be paid to this disease.

The Canadian Public Health Association visualizes, with the Canadian Medical Association, "a system of health insurance which will be more all-inclusive, efficient and sound than any which has been devised and operated elsewhere. It should place much emphasis on the prevention of disease and the development of a high degree of physical fitness, and should also include complete modern diagnostic and curative services."

Adequate preventive and public health provisions are outlined in detail in the submission of the Canadian Medical Association (Minutes of Proceedings and Evidence, No. 5, pages 138 and 139). The statement concludes as follows:

"Such a general programme would greatly assist in the fight to eliminate certain diseases such as diphtheria, whooping cough, tuberculosis, rickets, typhoid fever and smallpox, and would assist in the reduction in the frequency of many others, such as certain forms of mental disease, rheumatic heart disease, goitre, venereal disease and cancer.

"As years pass, the cost of curative services might be expected to materially decrease as disease is controlled and physical fitness increased."

It is evident therefore that the conception of health insurance which this Association shares with the Canadian Medical Association is one in which preventive services and public health occupy a most important place. In such a conception, *the benefits of health insurance must be made available to everyone*. It is significant that the representatives of labour, agriculture, national and local organizations of women, and the dental and nursing professions, all agree that the need in Canada is for *health insurance* and not merely *sickness insurance* which provides chiefly for the treatment of disease.

Preventive medicine and public health are directed not only towards the lengthening of life through the prevention of disease and premature death, but also towards all that pertains to health, both physical and mental. Social measures that give security, and free individuals from anxiety, make an important contribution to health. Likewise, the contribution of social workers and the provision of playgrounds and programmes for physical fitness render essential service in promoting health. In this conception, adequate local health services can only be provided through the physicians, nurses, dentists and the organized local departments of health and the community's welfare organizations.

2.

ALL PARTS OF CANADA MUST HAVE ADEQUATE LOCAL HEALTH SERVICES

The programme of health insurance that has been outlined calls for adequate community (local) health services which are to be provided by the medical, dental, and nursing professions in cooperation with the organized department of health and with the assistance of local voluntary health agencies. To reduce the

ravages of disease there must be an adequate and scientifically directed attack on the sources of disease and on those conditions which favour the occurrence of disease. *Every part of the country should be served by an adequate local health department.* Unfortunately, only part of Canada, and that chiefly the urban sections, has local health services under the direction of a medical officer of health who is paid for full-time service. Service rendered on a part-time basis is almost always insufficient and fails to protect the community when epidemics threaten or other emergencies arise. The greater part of the rural areas make inadequate provision for public health services. The need for such services is not confined to the more densely populated communities. In fact, the present need for more adequate sanitary facilities is generally in inverse proportion to the density of the population—the poorest sanitary conditions often being found in the smaller towns, villages and rural communities. Where the need, therefore, is the greatest, the ability of the communities to provide services is frequently the least. The necessity for strong community health departments for the control of communicable diseases, including tuberculosis and the venereal diseases, needs no emphasis. Similarly, the necessity for the regular supervision of perishable foods is obvious.

It is recognized that certain essential preventive services are now being inadequately carried out even in municipalities with well-organized local health departments. In small communities no provision whatever is officially made for essential preventive services for the expectant mother, the infant, the pre-school child and the school child. It is recognized that the practising physician should render prenatal supervision and continue health supervision of the infant and child. Considering Canada as a whole, it is probable that not more than 40 per cent of expectant mothers are reasonably well cared for during the period of pregnancy in so far as prenatal supervision is concerned. In the matter of infant hygiene, probably not more than 20 to 30 per cent of infants are receiving any acceptable type of medical supervision, either from public or private agencies or the private practitioner. Since these estimates relate to the whole of Canada, including large urban centres which generally are better served, the percentage of expectant mothers receiving prenatal care and of infants under health supervision must, in the villages, towns and rural areas, be small indeed. It is recognized that this percentage could be substantially raised if adequate local staff, both medical and nursing, were available and if the family physician could more generally assume this responsibility.

The pre-school age group is generally not receiving health supervision either through the local department of health or from the family physicians. Supervision of school children is provided in large centres of population but is almost entirely lacking in communities in which the service is rendered by a part-time medical officer of health and the local department of health is a minimum in organization and resources.

Local Health Services in Canada

In general, it has been required, under the Public Health Acts of the various provinces, that every community, village, town, township or city, shall have a local board of health, a medical officer of health (usually serving part-time), and at least one sanitary inspector. In Ontario, for instance, there are 575 medical officers of health serving 900 communities, including 32 cities (in many instances the same medical officer serves several communities), and of this number only 16 are paid for full-time service. As noted, the great majority of medical officers of health are serving on a part-time basis, receiving a few hundred dollars or less for their duties in this capacity.

As previously stated, part-time service generally is found to be inadequate, even in small municipalities. The part-time medical officer of health cannot initiate preventive services because there is no staff to assist him, such as trained

public health nurses or competent sanitary inspectors. There is no health department office apart from the physician's private office and in consequence few, if any, records are maintained. In fact, it is difficult for a physician engaged in private practice to discharge the duties of medical health officer without incurring disfavour when disciplinary action is required in the correction of faulty sanitation or in the control of communicable diseases. Such disfavour is not conducive to a successful private practice. Thus it is recognized by public health leaders that the direction of local health department services must be provided by a physician with special training in public health, giving his full time to the department.

How then is such service to be provided for those communities that are not large enough to maintain full-time health services?

This problem has been the subject of much study and trial on this continent and in Great Britain. Three methods of providing full-time services are in use in Canada. These represent in each instance the participation financially of the provincial government to a greater or lesser extent, varying from 20-30 per cent to 90 per cent of the total expenditure. The plans in use in Canada are: 1, health districts; 2, health units; 3, metropolitan health areas.

1. *Health Districts.* The province of New Brunswick is divided into ten health districts representing either a single county or several counties. Included in these districts are the cities and towns. The provincial government assumes the responsibility for the appointment of a qualified medical officer of health for each district. Approximately one-third of the cost of these district health services is met by the counties concerned. There are no local health officers in New Brunswick and the province is therefore served by ten full-time medical officers of health. Although the staff supplied in these districts is inadequate in so far as nursing and other personnel are concerned, the plan permits of additional staff being appointed by the provincial department of health when sufficient funds are available and trained personnel can be obtained. The responsibility for the organization and its direction is primarily placed with the provincial department of health, and the local community's contribution relates to the providing of local secretaries, offices, etc.

2. *Health Units.* In certain provinces of Canada, counties are administrative divisions, whereas in other provinces the unit of administration is the municipality. Health units providing full-time health services may embrace part of a county, a whole county, two or more counties, or two or more municipalities, depending on the density of the population. The population to be served by a health unit should not be less than 10,000 and preferably not more than 100,000.

A committee of the Canadian Public Health Association dealing with full-time health services has outlined a public health programme for a population of 100,000, indicating the services to be rendered and the reasonable minimum personnel required. These requirements constitute a yard-stick, and proportionate personnel and expenditures apply to smaller units of population. The population of 100,000 combines rural and urban areas, in a proportion of rural and urban in the ratio of 2 as to 3, the urban population being considered as including towns and larger centres. On the basis of these standards, an area of 1,000 square miles having a population of 30,000 would be served by an organization consisting of a full-time medical officer of health, five nurses, two sanitary inspectors, and office assistants.

At the present time four such units have been organized in British Columbia, nine in Alberta, three in Manitoba, one in Ontario, fifty-one in Quebec and five in Nova Scotia. Prince Edward Island, as at present organized, consists of one unit.

It is generally agreed from the extensive experience on this continent with full-time units that adequate services require the expenditure of \$1 per person per annum. Generally speaking, local communities contribute from one-quarter to one-half the total cost of the services, the provincial health authority supplying the balance. Since the public health authority assists substantially in meeting the cost of the services, the responsibility for the selection of trained personnel and for the direction of the programme is placed with the provincial department.

3. Metropolitan Health Areas. It is well known that the suburban areas adjacent to large cities frequently present urgent public health needs. In accordance with the general provision in Canada for local health services, each suburban municipality endeavours to provide some type of local services with part-time staff. A half dozen or more municipalities may be contiguous to a city, and it is obvious that economy and efficiency would result if a metropolitan health area embracing the city and the adjoining municipalities were established. Such a metropolitan area has been planned and in large measure achieved for Vancouver and its environs, through the active support of the Provincial Board of Health of British Columbia and with assistance from the Rockefeller Foundation. Consideration is being given to similar organization by several other cities.

Municipal Doctor Plan. As evidence of the efforts to meet better the local community needs, the introduction of the so-called municipal doctor plan in Saskatchewan and Manitoba is of interest. Approximately one-third of the municipalities in Saskatchewan have made arrangements whereby medical care is provided through the appointment of a salaried physician who serves also as medical officer of health. In Manitoba a number of communities have similar provision. This plan is primarily a plan for the provision of medical services.

It is evident, therefore, that the best method of providing full-time local health services has been determined by trial in the various provinces. Whether provided by health districts, largely financed by provincial departments of health, or by smaller health units in which the local community assumes a larger financial responsibility, the provision is made for properly qualified public health personnel serving on a full-time basis.

The Extent of Full-Time Health Services in Canada

To what extent is Canada provided with full-time health services? To answer this question, the Canadian Public Health Association, at the request of the Dominion Council of Health, made a survey in 1938 of all communities in Canada, including large cities. It was found that eighty-five communities, representing approximately 50 per cent of the estimated population of Canada, had the services of a full-time medical officer of health. The findings are presented in the Appendix (table I). As would be expected, the greater part of the population served in all the provinces, with the exception of Quebec, Prince Edward Island and New Brunswick, were urban populations. The percentage of the population in rural areas in the other provinces that had full-time health services was insignificant, constituting six per cent or less. Although additional full-time units have been established in Quebec and in several of the other provinces, and a few cities have been added to the list of the urban municipalities having full-time services, the data presented in this table represent substantially the situation at the present time.

It is seen at once that approximately half the population of Canada is not at present provided with full-time local health services, and that very large sections of the country are without the services which are essential in health supervision. This need can be met through full-time health units. Such units, cannot, however, be provided by the local municipalities, but require direction and financial assistance from the provincial departments of health.

3.

THE PRACTISING PHYSICIAN SHOULD PROVIDE BOTH
PREVENTIVE AND TREATMENT SERVICES, AND
REQUIRES ASSISTANCE FROM AN ADEQUATE
LOCAL DEPARTMENT OF HEALTH

On many occasions the Canadian Public Health Association has expressed the desire of its members that the family physician should assume, as a responsibility for those under his care, certain preventive services, some of which are being furnished through departments of health. The association believes that the responsibility for the maintenance of health and the prevention of disease should be shared by the physician in general practice whose professional duties are in the main exercised through the fundamental unit of society, namely the family.

Since the effectiveness of preventive measures may be lost unless action is taken as early as possible, the general practitioner, who is the first to see the patient, must inevitably play a most important part in the success or failure of preventive medicine. He is thus in a preferred position to initiate at the earliest possible moment the train of events, either through his own administrations or with the aid of experts, which lead most promptly and effectively to the control of the diseases which he encounters. The general practitioner has not always, in the past, either seized the opportunity or accepted the responsibility in an effective or realistic fashion. There are undoubtedly reasons, and these would largely be removed if the practice of preventive medicine formed an integral and essential part of health insurance. The general practitioner is hesitant, under present conditions of private practice, to advocate preventive services from which he will benefit financially. In other words, he does not wish to impose an extra burden upon the family for medical attention which has not been specifically requested. The patients of the general practitioner are often not sufficiently aware of the value of such supervision to request the physician to render preventive services for which payment would willingly be offered. Under health insurance the physician would receive remuneration for the services rendered in the practice of preventive procedures. A further reason is that family physicians are often not fully aware of the opportunities for service which preventive measures offer.

In the submission of the Canadian Medical Association such an extension of services to be rendered by family physicians is outlined. The family physician can and should provide adequate prenatal supervision of the expectant mother, as well as care for her at the time of confinement. In addition to safeguarding the health of the mother and baby, he should continue to serve as the family health adviser, maintaining watchful supervision through the pre-school and school years, and if found practicable, continue such supervision into adolescence and adult life. As stated in the submission of the Canadian Medical Association, "the family must be the unit."

In including a larger measure of preventive medical services in the practice of the family physician, provision must be made for the proper payment of such services. Payment on a per caput basis would greatly facilitate the rendering of such service by the physician. Reference to the subject of payment is made in this submission only because in the judgment of public health authorities payment on a fee basis for each service rendered would be impractical and tend to defeat the fundamental conception of the prevention of sickness and disability.

*The Relationship Between the Practising Physician and the
Local Department of Health*

If the general practitioner is to render such service, it is necessary that there should be a well-established community health service. In order that an adequate health programme may be provided, there must be the closest relation-

ship between the practising physician and the local department of health. Some preventive measures, such as school medical services, tuberculin testing and chest X-ray examinations, and the treatment of venereal diseases, may be more economically and conveniently provided through clinics or other group organizations arranged by the department of health and the practising physicians. Such provision calls for a complete understanding of the needs and resources of the community by the physicians and the health department. This can only be attained by an intimate relationship between the medical officer of health and the physicians of the community. Such a relationship would assure the success of the local health programme and progress towards the common objective of good community health.

It is at once appreciated that the local department, through its health education programme, informs the public of the essential preventive service which the family physician is prepared to render. Only in this way can the plan of having the family physician serve as a health adviser really function. In the effective working of the plan by which the general practitioner will render essential preventive services, it is obvious that supervision of the preventive activities of the general practitioner by a competent authority is essential. In the opinion of this Association, the physician qualified by post-graduate training in public health, serving as medical officer of health, is the logical authority for providing such supervision.

4.

ADEQUATE HEALTH DEPARTMENT SERVICES DEPEND ON PROVINCIAL HEALTH DEPARTMENTS FOR DIRECTION AND FOR FINANCIAL ASSISTANCE

The British North America Act provided the foundations of a national, centralized government and defined the respective responsibilities of the federal and provincial governments. The term "public health" was not in use at that time; in fact, it was not until 1875 that the great Public Health Act which gave prominence to this term was passed by the British parliament. Only brief references are made to health matters in the British North America Act, and these place with the federal government the responsibility for the census and statistics, quarantine, and the establishment and maintenance of marine hospitals. All other responsibilities, including the establishment and maintenance of hospitals and asylums, are left to the provincial authorities. This would seem to imply that treatment services are primarily the responsibilities of the provincial authorities.

The first provincial board of health in Canada was established in Ontario in 1884, thirty-five years before a federal department of health was created. The Public Health Act of 1875 of Great Britain provided for local health services for all communities under the central authority, and required that every municipality must appoint a physician to serve as medical officer of health, and also a sanitary inspector. The Public Health Acts of a number of the provinces in Canada made similar provisions, so that the general plan followed in providing local health services has been the appointment of a local board of health, a physician serving as health officer, and a sanitary inspector. The development of provincial departments of health has progressed rapidly since the close of the last war. New Brunswick, in 1917, was the first province in Canada to have a Minister of Health, and such a step has since been followed by a number of the other provinces. This is a significant development, in that health is represented in the provincial Cabinets.

Provincial Health Programmes

Provincial health programmes as undertaken by provincial departments of health may be considered as (a) directional, (b) consultative, (c) educational, and (d) direct service. In general, the programme provides preventive services and treatment services. The Public Health Act and the other Acts with their regulations provide for the establishment of acceptable units of local public health service and for meeting the problems of environmental sanitation, control of communicable diseases, the supervision of milk and other perishable foods, and other public health responsibilities. As part of the *directional service*, the provincial department is responsible for setting up minimum standards in respect of qualifications of public health personnel employed both by provincial and local departments, for surveys of health needs, for the collection and tabulation of statistical data in respect of births, marriages and deaths and the extent of illness. Finally, the provincial department is responsible for the distribution of provincial and federal subsidies.

In providing *consultative services*, it is essential that the department be equipped with a well-trained staff so that direction may be given to the local community programmes, particularly in such matters as the sanitary disposal of refuse and sewage and the provision of satisfactory water supplies. The departmental staff must be available to aid local authorities in the event of outbreaks of communicable disease and to provide general supervision of local services. Assistance is given also in the interpretation of government legislation.

Of great importance is the *educational service*, which may be considered as informative, relating to the preparation and distribution of informative material; and as promotional, serving to stimulate local authorities and others to the point where necessary services are established—for example, the establishment of larger units of local administration or services such as public health nursing, nutrition programmes, etc.

Under *direct services*, the department provides central and branch laboratories for the examination, without charge, of bacteriological and other specimens. In all the provinces some plan is in effect to assist physicians in the treatment of certain communicable diseases through the supplying of the essential vaccines and serums for the prevention or treatment of smallpox, diphtheria, typhoid fever, scarlet fever, whooping cough, tetanus, and epidemic meningitis. In a number of provinces these products are made available to physicians without charge, and insulin is also supplied for needy diabetics. Diagnostic clinics for the detection of mental illness, tuberculosis, crippling, etc., constitute another direct service which is offered by provincial departments.

In so far as *treatment services* are concerned, provincial health programmes have provided for the institutional care of the mentally ill and the feeble-minded, for the treatment in sanatoria of patients suffering from tuberculosis, and for the treatment of venereal disease. Provision is made also for the treatment of the major communicable diseases when these are present in epidemic proportions, such as outbreaks of infantile paralysis, epidemic meningitis, etc. In some of the provinces provision is made also for the care of cancer patients.

Such a programme presupposes adequate funds, a suitable type of local administrative unit which is both geographically and economically sound, and the availability of sufficient personnel with the required qualifications.

Reviewing public health progress in Canada, it can well be said that the achievements are to a very large extent a record of achievements of provincial health departments.

The Inadequacy of Present Programmes

To what extent are the provincial governments providing the type of provincial health programme which has been outlined and which is considered to be a reasonable minimum?

An answer is to be found in part in the expenditures for so-called "public health purposes" made by the provincial governments. In a study of these expenditures for the year 1937, made at the request of the Dominion Council of Health, it was found that the provincial governments carry a very large burden of hospital costs, including general hospitals, mental hospitals, and tuberculosis sanatoria. Because of these large expenditures, the amount available to the provincial health department is definitely limited; and when considered from the standpoint of the provision of preventive services, it is entirely inadequate for the need. These data are presented in the Appendix in tables II, III, IV and V.

In table II the expenditures by provinces for health and for general and mental hospitals are given. Of the total expenditures for the nine provinces, amounting to approximately \$22,000,000, about \$6,000,000 represented expenditures for public health services and \$15,000,000 represented hospital expenditures.

Table III presents data concerning expenditures for general and mental hospitals by each of the provinces. This indicates the very large expenditures for the maintenance of mental hospitals, representing 44 per cent of the total expenditure of \$22,000,000 for all health purposes.

Table IV presents expenditures by provincial governments for health services, showing separately the expenditure for tuberculosis. It will be seen that the expenditure for tuberculosis equalled the total of all the other provincial public health expenditures. Of the total provincial health expenditures of approximately \$6,000,000, \$3,000,000 was required primarily for the treatment of tuberculosis.

From these tables it is evident that hospital costs constitute 84 per cent of the total provincial government health expenditures (mental hospitals 44 per cent, public hospitals 27 per cent, and tuberculosis sanatoria 13 per cent), leaving only 16 per cent for the maintenance of the provincial public health services. In referring to the large expenditure for tuberculosis, which equals the total of all the other expenditures of the provincial department of health for public health, there is no suggestion that less money should be spent on the reduction of this disease. It has been demonstrated clearly that tuberculosis death rates can be rapidly reduced if free treatment is provided in sanatoria and an adequate province-wide programme of case-finding, including the examination of contacts, is undertaken. In Ontario the number of deaths from this disease has fallen from 3,484 in 1900 to 1,100 in 1941, in spite of the increase in the population from 2,183,000 in 1900 to 3,788,000 in 1941.

Table V presents the estimated expenditures which could be considered preventive, in contrast with treatment. These amount to approximately \$2,000,000—or 9 per cent of the total health expenditures. It is striking that such a small percentage of the expenditures which are frequently referred to as "public health expenditures" is directed towards the prevention of disease, both physical and mental, and the forwarding of programmes for the maintenance of health through a wider knowledge of nutrition, better sanitary conditions, better housing and other fundamental health requirements. There is general recognition of the need for more preventive services, but it is obvious that larger support must be made available through provincial governments if such services are to be possible. As previously stated, the very large burden of hospital costs placed upon provincial governments has prevented the provision of funds for the extension of preventive services by provincial departments of health. The application of preventive medicine has achieved outstanding success in reducing the number of deaths of mothers and infants, but here again the amount of money available in various provincial departments of health for such services is so small that only the larger provinces are able to provide suitable organizations with trained personnel to give direction. Nutrition and industrial hygiene

are subjects which are constantly before us to-day, yet only one province in Canada has a division of nutrition, and the efforts in industrial hygiene have been severely limited by the funds available.

The inadequacy of the present preventive health services is generally recognized. In the submission of the Canadian Medical Association it is stated:—

The present programme of preventive medicine in the country is far from adequate. Our major emphasis in the past has been on the cure of disease—on negative health, as it were. There should be more emphasis in the future on positive health, on preventive medicine and public health. It is less costly to prevent disease than to cure it, yet our progress in this direction, although steady and gratifying, has been far too slow.

In making these statements there is no implication in the slightest that the provincial, federal and municipal departments of health have not done excellent work. Actually they have accomplished much, frequently under considerable handicap. But the results have been much less than could have been achieved had adequate funds been available. It is unfortunate that, while, in the past, money has been freely available for so many other purposes, yet so much difficulty has been encountered in obtaining adequate funds for effective programmes of preventive work and public education on health matters.

It is when the present situation in regard to local health services is remembered that it is appreciated that little change from the present unsatisfactory conditions of inadequate service *can* be expected until financial assistance is provided. Generally, the communities most in need of more adequate service are the communities least able financially to provide it. In any case, they are the least likely to attempt to improve conditions unless assistance be given to them and direction provided. It is logical that such assistance and direction should be provided through the provincial government. But it is also obvious that the heavy expenditures by provincial governments for hospitalization and other costs limit their assistance to local communities.

The answer is to be found in a policy of grants-in-aid from the federal government to provincial governments, to permit of sharing the burden of certain diseases such as tuberculosis and the problem of mental illness, and to provide financial assistance to local communities for health services.

5.

THE FEDERAL ROLE IN PUBLIC HEALTH

It was not until the close of the last war that Parliament created a federal department of health for Canada—the Department of Pensions and National Health. Prior to 1919, health activities were divided among the several departments of government, including agriculture, marine, fisheries, and inland revenue. The control of tuberculosis was the responsibility of the Department of Finance and the Conservation Commission. A National Council of Health under the Conservation Commission advised the federal and provincial governments on health matters. Co-ordination was lacking. The Canadian Medical Association and the Canadian Public Health Association from time to time urged the federal government to create a federal department of health.

By the terms of the Act establishing the department in 1919, its duties and powers extend to “all matters and questions relating to the promotion and preservation of the health of the people of Canada”, but it is expressly stated

that the department shall not exercise any jurisdiction or control over any provincial or municipal board of health or other health authority operating under the laws of any province. In the Department of Health, Canada has therefore a department which assumes the statutory responsibilities placed upon it by parliament, and affords, through its divisions, technical advice and other assistance to the provinces. The creation of the department has fostered an intimate relationship between the provinces and the dominion government in health matters; and in this development the Dominion Council of Health—the advisory body representing the executive medical health officers of the provinces, with certain other representatives—has played an important part. The establishment of the department gave an impetus to the development of public health in Canada and each of the provincial governments enlarged and strengthened its department of health. As previously stated, however, local health services have generally continued to be inadequate.

The Responsibilities of the Federal Department of Health

Among the responsibilities of the federal department are maritime quarantine, medical inspection of immigrants, sanitation of common carriers, the administration of the Food and Drugs Act, the Proprietary and Patent Medicine Act, the Leprosy Act, certain sections of the Canada Shipping Act relating to the care of ill or disabled seamen, and certain sections of the Public Works Act. One of the most important responsibilities of the department is to maintain the quality of all foods and drugs. Canada has a most comprehensive Food and Drugs Act and an effective organization for its administration. Included in this responsibility is the supervision of serums and vaccines, vitamins, and certain glandular products, for which there are international standards. Control of these products is carried on by the Laboratory of Hygiene. One of the functions of the Laboratory of Hygiene, under the Act establishing the department, is the conduct of research. The Department of National Health co-operates with the Dominion Bureau of Statistics in the provision of vital statistics for Canada. The international responsibilities of the department include maritime quarantine, the control of narcotic drugs, and the sanitation of international boundary waters.

Although, as mentioned, the creation of the department resulted in the bringing together of the health activities formerly assumed by a number of departments of government, for obvious reasons the administration of the Animal Contagious Diseases Act and the Meat and Canned Foods Act, which have very definite public health aspects, was left with the Department of Agriculture. The health of Indians, including tuberculosis control, is at present a responsibility of the Department of Mines and Resources.

Grants-in-Aid for the Extension of Health Services

Although an interpretation of the British North America Act places the responsibility for treatment of disease with the provincial governments, the magnitude of the problem of certain diseases—for example, mental illness, tuberculosis, and venereal diseases—leads inevitably to their consideration as national problems. When the extent of the venereal-disease problem was recognized, at the time of the creation of the Department of Pensions and National Health in 1919, provision was made not only for the establishing of a division of venereal-disease control but also for providing assistance to the provincial departments of health for the maintenance of treatment clinics. An amount of \$200,000 was voted and distributed annually to the provincial departments during a period of years. Although the grants were withdrawn and the venereal-disease division disbanded in 1932, the value of grants to assist the provinces in essential public health work had been clearly demonstrated. It is encouraging that provision has been made in this year's estimates for the restoration of venereal-

disease grants and that the division of venereal-disease control has been re-established. Lieutenant-Colonel D. H. Williams has been appointed to head this division, and also to direct the venereal-disease control programme in the armed services. Thus it is possible for a unified civilian and military programme to be carried forward from coast to coast. This is an example of federal leadership in public health, a type of service which the federal department can render and which could be duplicated with advantage in other fields of communicable disease control.

The policy of grants-in-aid, established in regard to venereal-disease control, should be broadened, as the extension of health services for all communities calls for assistance. Such financial aid from the federal government should be made available to all provinces meeting the reasonable requirements of the federal authorities, irrespective of whether or not a province implements the health insurance plan.

It has been demonstrated in Great Britain that grants for public health purposes made by the central authority result in larger expenditures by local communities, with the consequence that greatly increased services are rendered. In other words, local communities have not paid less, but have contributed more, as a result of assistance from the central authority. In the United States of America, the provision of funds under the Social Security Act of 1937 has resulted in a striking advance in public health services in every state. What is of great significance is that the granting of federal funds to the states has resulted in greatly increased appropriations for public health being made both by state and municipal authorities. It cannot be said that federal assistance has diminished the extent of state participation in public health, or has reduced municipal expenditures. Federal participation has made possible effective programmes in each state and has proved to be the only way of adequately dealing with this problem—namely, on a *national* basis.

6.

THE ADMINISTRATION OF HEALTH INSURANCE AND PUBLIC HEALTH

The experience in Great Britain indicates that very definite advantages derive from the close integration of the administration of health insurance both with the central health authority and with the local health authorities. With the establishing of the Ministry of Health in 1919, provision was made for an intimate relationship in the administration of public health and health insurance. This is obtained through the administration of health insurance not only for England and Wales, but for Scotland and Northern Ireland as well, through a joint insurance commission which in turn functions through the insurance division of the Ministry of Health.

In the submission to this committee by the deputy ministers of health, administration through either a health insurance commission or a provincial department of health was suggested. The Canadian Public Health Association endorses this suggestion that choice of administration be given the provinces. If administration is provided through the provincial department of health, the deputy ministers recommended that provision should be made for establishing a separate division and for assuring the selection of a competent director. If administration is provided through a health insurance commission, they recommended that the commission consist of from three to five salaried members. In either plan, a strong provincial advisory council on health insurance, representative of all groups concerned in health insurance, should be provided. The Canadian Public Health Association approves of these recommendations and believes that administration through a health-insurance division of a provincial

department of health best permits of the proper integration of health insurance and public health.

How the need for adequate health department services for the whole of Canada can be met has been thoroughly studied by the provincial departments of health. Their findings have been given to the Canadian Public Health Association's Committee on Full-Time Local Health Services. The association is therefore able at this time to present a summary of these plans as submitted by each provincial department of health. To provide for those areas other than self-contained cities and metropolitan districts, 250 health units would be required. These units would require approximately 400 physicians with special training in public health, 1,500 public health nurses, and 500 sanitary inspectors, together with office assistants and other technical staff. The total expenditures to provide for these areas would not exceed \$8,000,000. To-day the estimated expenditures in rural areas for services provided by the 84 units now operating is approximately \$1,500,000. Thirty-five urban units, including metropolitan health areas, would provide services for all the large centres of population. In this way no part of Canada would be without public health supervision.

In the plan of administration as proposed in schedule B, constituting the Provincial Health Insurance Act, provision is made in section 42 (1) for the division of the province into "public health regions" and "health insurance regions", and in section 42 (2) for a unified administration of all public health and health-insurance services. These provisions, as well as the provision of section 42 (3) for the most appropriate division of the province into public health regions and health-insurance regions, are heartily endorsed by the Canadian Public Health Association, as they provide for the essential unification of these services. In this way, intimacy of relationship can be maintained between the practising physicians, hospitals, and the organized departments of health, and economy of administration effected.

7.

QUALIFIED PUBLIC HEALTH OFFICERS, PUBLIC HEALTH NURSES, AND OTHER PERSONNEL ARE ESSENTIAL IN PROVIDING PUBLIC HEALTH SERVICES

Of fundamental importance is the providing of trained personnel to serve in public health departments. It is recognized that the medical officer of health is a specialist in the public health aspects of medicine and requires post-graduate training and experience in order to direct public health programs effectively. Similarly, it is necessary for nurses and other personnel to receive post-graduate or other special training in public health.

Experience in the United States and Canada in obtaining physicians with post-graduate training in public health has shown that it is necessary to give financial assistance in the form of fellowships. Post-graduate courses occupy from eight months to a year. In order that physicians may receive such special training, assistance has been found necessary, as the undergraduate course in medicine, with internship in hospital, occupies at least six years and there is little opportunity during the course to accumulate resources for post-graduate training. It must be remembered also that physicians engaged in public health work receive less in the way of remuneration than do their colleagues in practice, particularly those of the latter who are specialists. Because they are entering public services and receiving small salaries, it is reasonable that the state should

assist with their post-graduate training in public health. Similar provision is desirable to make it possible for graduate nurses and sanitary engineers to obtain post-graduate training, and assistance is also required if properly qualified sanitary inspectors are to be available.

Provision should be made by the federal government to assure properly qualified public health personnel if the investment in local health services is to yield adequate returns.

8.

THE IMPORTANCE OF MEDICAL RESEARCH TO HEALTH INSURANCE

When health insurance was introduced in Great Britain in 1911, provision was made that a small part of each contributor's annual payment should constitute a fund for the advancement of medical research. As a result of this foresighted provision, the Medical Research Council of Great Britain was established, the National Institute for Medical Research organized, and great progress made in medical research in the British Isles. As the years have passed, additional funds have been made available, which is ample evidence of the recognition of the value of this investment.

Little provision is made by the dominion government to further medical research in the universities and hospitals in Canada, apart from limited funds made available during the past few years through the National Research Council of Canada. The work of the Associate Committee on Medical Research, organized in the National Research Council just prior to the war, has demonstrated the importance of leadership in this field, as well as the need for greatly increased funds to support research. It will indeed be a most serious loss if, in the provisions of national health insurance, no provision is made for medical research in Canada. Only by advances in our knowledge can more effective treatment and prevention be accomplished and health insurance be made economically possible and effective in its objective of better health for the people of Canada.

9.

SUMMARY

The plan of health insurance outlined by the Canadian Public Health Association visualizes:

1. The benefits of health insurance afforded to every citizen of Canada.
2. The provision of adequate local health services for every community by physicians, dentists and nurses, and full-time local health departments.
3. The family as a unit, which would receive continuous health supervision and treatment when required, from the physician of choice, with adequate diagnostic facilities and the services of specialists provided to assist the family physician. (For the first time in any health insurance plan the family physician would render health advice and would advance measures for the prevention of disease, as provision would be made for payment for both preventive and treatment services.)
4. The administration of health insurance federally through a Division of Health Insurance in the Department of National Health, under the Minister of National Health, thus permitting of the development of health insurance and public health in a co-ordinated and effective plan.

5. The administration of health insurance provincially through a Health Insurance Commission, or, preferably, through a Division of Health Insurance in the Provincial Department of Health, thus permitting of the closest relationship in the forwarding of a broad program of health.

6. The administration of health insurance and public health locally through the suitable division of each province into districts or regions organized as full-time health units for the provision of local health department services and for the local administration of health insurance.

7. The provision of grants-in-aid to provincial governments to further the control of such national problems as tuberculosis, venereal diseases and mental illness, and to permit of establishing full-time health units to serve all parts of each province. Such a policy should be implemented either as a part of national health insurance or independently, in view of the evident need.

8. The provision of assistance, through fellowships, for the training of public health personnel, including medical officers of health, public health nurses, sanitary engineers, and sanitary inspectors.

9. More adequate provision for medical research in Canada.

That is the end of the presentation, Mr. Chairman. Dr. Groulx, the President of the Association will present a summary in French.

Dr. ADELARD GROULX, called.

IMPORTANCE OF PREVENTIVE MEDICINE AND PUBLIC HEALTH IN CONNECTION WITH NATIONAL HEALTH INSURANCE

A plan submitted to the Special Committee on Social Security of The House of Commons by The Canadian Public Health Association, May, 1943

Dr. Adelard Groulx

THE CANADIAN PUBLIC HEALTH ASSOCIATION—ITS ORGANIZATION AND ITS OBJECT

The Canadian Public Health Association was incorporated in 1912 under the terms of a Dominion charter. It is a professional society representing those who serve the cause of public health in the official services or voluntary organizations. Its members are recruited from among some 1,900 doctors who serve as medical health officers throughout Canada, dentists, nurses and engineers and also from among other trained professional bodies serving in this field. During the thirty years of its existence, the most outstanding leaders in the realm of public health have served as officers. Hence, the Canadian Public Health Association feels it speaks on behalf of those who are best acquainted with the present position of the public health services of the whole of Canada. The Canadian Public Health Association strongly insisted on the requirements of a health insurance and restated its opinion with respect to the necessity of a national scheme in the following resolution adopted at the 31st congress of the Association, held in Toronto in the month of June, 1942:

Whereas there is urgent need in Canada for the more adequate provision of general medical, dental and nursing services,

And experience in Great Britain and other countries has demonstrated the value of a system of compulsory contributory health insurance,

And this association believes that in any health insurance programme, adequate provision for preventive service is essential,

Be it resolved that this association endorses the principle of national health insurance and urges that the provision of preventive services should form an essential part of this programme.

THE PURPOSE OF THIS PROJECT

The purpose of this project is to show:

1. That preventive medical services are essential to the success of health insurance.
2. That all parts of Canada should have adequate health services.
3. That the practising physician must render services from the dual standpoint of prevention and treatment; and that, in order to discharge his duties in that respect, he must receive the assistance of an adequate local health service.
4. That local health services count on provincial health departments for guidance and financial assistance.
5. That the grants of the Federal Government present an opportunity to deal with the urgent problems of public health, especially the control of tuberculosis, the treatment of mental diseases, the control of venereal diseases and the development of adequate local health services throughout the whole Dominion.
6. That it is essential that health insurance and public health should form part of provincial and local administration.
7. That the utilization of part of the funds of national health insurance for the advancement of medical research work in universities or in hospitals is of great importance to the future of health insurance.
8. That the granting of a sum of money for the training of a qualified public health staff is of paramount importance.

CONCLUSIONS

The health insurance plan recommended and designed by the Canadian Public Health Association represents:

1. Health insurance benefits for every Canadian citizen without distinction of financial standing.
2. Provisions for local health offices in every locality under full time medical officers.
3. Continual health supervision of every family as a unit with treatment when required, by a doctor of their own choice; with adequate facilities of diagnostic and services of specialists to assist family physician.

For the first time in any health insurance plan the family physician would be able to give advice and point out prevention measures, as he would be paid for this exactly as he is paid for treatment.

4. Administration of health insurance federally through a Health Insurance Division in the Department of National Health, under the jurisdiction of a minister.

This would permit the development of health insurance and public health under a co-ordinated and efficient system.

5. Administration of health insurance provincially through a health insurance commission, or rather, through a well-organized health insurance division in the Provincial Department of Health.

This would establish closer relations in the development of a larger health programme and would insure the efficiency of the health insurance plan.

6. Administration of health insurance and public health locally through the appropriate subdivision of each province into districts or areas organized as full time health units to manage the necessary health services and the local health insurance plan in the locality.

In this way the services would give the maximum of efficiency with the minimum of expense.

In order to put this plan into effect certain amounts should be allocated to help the provincial governments in their plans of control of such national problems as tuberculosis, venereal and mental diseases and to allow the creation of full time health units operating throughout each province.

By including a large part of the services of preventive medicine in the practice of the family doctor, sums must be ear-marked for the payment of such services. Payment on a per capita basis would greatly facilitate the task of the doctor to render such services. Reference is made in this project to this matter of payment merely because, in the opinion of public health authorities, payment on the basis of fees for each particular service would be unpractical and would not be in keeping with the basic conception of sickness prevention and inability to work.

It is of the utmost importance that sums be set aside for the training of a staff qualified in public health, including medical health officers, public health nurses, sanitary engineers and inspectors. Public health scholarships to help the staff in the courses of higher learning are essential.

Finally, the setting aside of sums to ensure the pursuit of medical research work in Canada is essential to the success of health insurance.

The CHAIRMAN: Thank you, Dr. Groulx. Any questions?

By Mr. Hurtubise:

Q. In the first presentation it was mentioned that in the province of Quebec there were very many more sanitary units than elsewhere. I would like to have Dr. Groulx tell us how it has been working in practice. Has it been very easy to work and what are the benefits it has brought to the public? —A. I am not the provincial officer in Quebec. I am appointed by the municipal organization in Montreal and naturally I am not very familiar with the details of the Quebec sanitary health units. It was mentioned that we have about fifty-one sanitary units throughout the province of Quebec under the direction of a full time health officer who is well qualified. I think most of them receive their qualifications in American and particularly Canadian universities, Toronto. They are assisted by a regular staff of nurses and sanitary inspectors. Depending on conditions there are one or two sanitary inspectors and likewise the same number of visiting nurses. Each unit is responsible for the health conditions of the population of one or two counties of the province. I am giving that with reservation because I have no data before me but the health conditions in these counties so organized have been improved. The results have been very encouraging and death rates have decreased in many of them, and the general result for the province is that they contributed very much towards the improvement of health conditions and a decrease in the different causes of death throughout the province.

Q. I would like to put two sub-questions. Have you had much difficulty in getting the personnel as far as doctors, nurses and others? The second question is, what co-operation do you get from the public? Do they appreciate it and do they co-operate with the unit? —A. I think I can answer those two sub-questions. The Ministry of Health now have no difficulty in getting the personnel, doctors and nurses, and the same for inspectors. As I told you a doctor before taking charge of a unit is sent for special post-graduate studies in public health and the same also for nurses because they have many requests and applications for nurses. As to the actual state of mind in the province I think that the population is encouraging the movement. As I mentioned last fall in Toronto there is a law by virtue of which the province can impose such a unit on a county but it has never been necessary to go that far because the demands are such that the Minister cannot answer all the requests made to him. I think this organization is going pretty well now and before long the field will be covered. We are trying to organize the city of Montreal on the same basis as the rural health districts.

By the Deputy Chairman:

Q. In the preparation of the doctors who are at the head of these health units in Quebec does the province not pay a certain amount for the special training that is needed?—A. I think that possibly Dr. Defries can answer that better than I can, but I think some grants are given by the province and there are some made by the Connaught laboratories.

The DEPUTY CHAIRMAN: Dr. Phair, would you answer that question?

Dr. PHAIR: Might I suggest that Dr. Defries answer the question in view of his association with the training centre?

Dr. DEFRIES: Mr. Chairman, in answer to the question, throughout Canada fellowships have been made available to provincial departments of health through the Rockefeller Foundation. 109 such fellowships have been made available and trained officers are the result in the different provinces. Assistance has been given also by the Connaught laboratories in the University of Toronto. Some fifty fellowships have been given supplementing those given by the Rockefeller Foundation. In addition provincial departments of health have tried to make it possible for their members to go as well. Many of those who have come have, of course, received a fellowship but practically all have received some assistance, either part salary or permitting them to go on leave, as it were, but without such assistance it would be difficult for many of the members of the medical profession to obtain post-graduate training.

Mr. LECLERC: I think I might answer your question to a certain extent. As far as co-operation from the public we find that the results are very good in the province of Quebec. While I was mayor of my town we organized a sanitary unit. We had a very devoted doctor. He took his job to heart and the government sent him away on several trips travelling throughout the United States to different universities and in that way he took a post-graduate course and was away for several months. The co-operation has been 100 per cent from the public.

The DEPUTY CHAIRMAN: Any further questions?

Mr. MCGARRY: In Dr. Defries' brief on page 9 the second paragraph deals with the inadequacy of the present programs and refers to the inadequacy of hospitalization in matters dealt with by general hospitals, mental hospitals and tuberculosis sanatoria. I was wondering if the inclusion of a convalescent hospital would be worth while. I think it would relieve the inadequate hospitalization which deals with these matters that I referred to and at the same time the inclusion of a convalescent hospital in this plan would not impose any greater costs on the subscribers to this joint national health hospitalization. I was wondering if that had been given any consideration.

The DEPUTY CHAIRMAN: Dr. Phair, would you answer that?

Dr. PHAIR: Gentlemen, I think that everybody is in sympathy with the plan whereby part of the load now borne by the Public General Hospital might be borne by a convalescent hospital, which could be operated according to the accepted belief at a much more economical figure.

The reason for our failure to incorporate in the brief any reference to that type of desirable set-up is that as far as the committee of the association is concerned it is our primary purpose to emphasize the desirability of preventive service. But the association is quite completely in accord with the principle of a convalescent hospital.

Mr. FULFORD: Mr. Chairman, I should like to ask to date has there been much trouble with the local medical association cooperating with the medical officers of health? The reason I bring up that question is this: I know of one community where certain members of the local medical association refuse to report communicable diseases to the medical officers of health because they do not like them personally.

Dr. PHAIR: Mr. Chairman, I can quite appreciate the situation which Mr. Fulford refers to as a possibility. In smaller centres where the physician who has the office of part-time officer of health is, to all intents and purposes, in conflict with his colleagues in the practice of curative medicine, and as was referred to, on the occasion when disciplinary action is necessary he alienates certain members of the community; but he is also much better known to his colleagues than perhaps the health officer of a municipality who is in a larger centre and who, to all intents and purposes, may be almost perfect in his personal relationship. I am speaking of the province of Ontario. I suppose the same situation obtains in other provinces. It is possible for a situation such as described by Mr. Fulford to exist in a community, failure on the part of a physician to report particularly in regard to communicable diseases. I would not want the committee to get the idea that it is a general practice, but it could under the general program exist and handicap that part of the work.

Mr. FULFORD: Would you agree with this, when health insurance goes through and full-time officers of health are appointed, that lack of co-operation will disappear?

Dr. PHAIR: That is true; it should disappear, Mr. Chairman.

The DEPUTY CHAIRMAN: Are there any further questions?

Mr. VENOIT: In the summary it is pointed out that the Canadian Public Health Association prefers the provincial administration through the Department of Health rather than through a commission. Would the doctor be kind enough to explain why this preference is expressed?

Dr. PHAIR: Mr. Chairman, the association felt that we had an equal interest both in the promotion of the preventive procedures which are essential to the conduct of a satisfactory health program, and the curative ones. The closest integration is desired in the promotion of both of those by all of the representative people in both the professions of medicine in the community; if you have one individual administratively responsible for the conduct of both programs, as would be the Minister of Health in the appropriate province, that would be the simplest and most expeditious way of securing a maximum of co-operation and integration of the two services.

Mr. VENOIT: May I follow that up, Mr. Chairman, with another question? What about the certain amount of doubt that is expressed in some quarters with regard to political interference with the carrying out of a health insurance program if the administration is left in the hands of the Department of Health?

Dr. PHAIR: I am sure, Mr. Chairman, that I could not presume to answer that question, not that I would not be willing to. The possibility of political interference adversely affecting the program if it were left under the auspices of the Minister of Health strikes me this way: I can only say that would be a reflection on the interest and desire on the part of the government to tie in with the provinces to promote what they already would have substantial commitments in.

The DEPUTY CHAIRMAN: I am taking it for granted it is the desire of the committee to have placed on the record also the appendices which are contained at the end of Dr. Defries' brief.

Some Hon. MEMBERS: Yes.

The DEPUTY CHAIRMAN: I am sure I am expressing the sentiments of the whole committee in thanking very sincerely Dr. Defries, Dr. Groulx, and their associates, also the association which they represent, for the admirable brief which has been presented to us today. This brief will undoubtedly be of great assistance to the committee in its consideration of the very important subject of social security. I thank you very much.

We shall adjourn now until Tuesday of next week.

—The Committee adjourned to meet again on Tuesday, May 25, at 11 o'clock a.m.

TABLE I
FULL-TIME† LOCAL HEALTH SERVICES IN CANADA, 1938, BY PROVINCES

Province	Population Estimated	Full-Time Departments			Population Served			Per cent of Total Population		
		Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
British Columbia.....	761,000	6	2	4	397,305	354,823	42,482	52.0	46.5	5.5
Alberta.....	783,000	4	2	2	209,774	174,613	35,131	26.7	22.2	4.5
Saskatchewan.....	941,000	2*	2	0	95,502	95,502	.....	10.1	10.1	.....
Manitoba.....	720,000	4*	3	1	280,554	256,286	24,268	38.9	35.5	3.4
Ontario.....	3,731,000	14	13	1	1,501,890	1,408,690	93,200	40.2	37.9	2.4
Quebec.....	3,172,000	42	5	37	2,362,321	1,131,694	1,230,627	74.6	35.8	38.8
New Brunswick.....	445,000	10	.....	.....	445,000	.....	.....	100.0	.....	.....
Nova Scotia.....	548,000	2	1	1	203,000	70,000	133,000	37.0	12.8	24.2
Prince Edward Island.....	94,000	1	.....	.....	94,000	.....	.....	100.0	.....	.....
CANADA.....	11,195,000	85	.....	.....	5,589,316	.....	.....	50.0	.....	.....

† Full-Time Medical Officer of Health.

* Excluding Municipal Physicians.

TABLE II
EXPENDITURE FOR HEALTH AND HOSPITALS BY PROVINCIAL
GOVERNMENTS, 1937

Province	Population	Provincial Health	Provincial Hospital	Total Expenditure Health and Hospitals	Per Caput Expendi- ture
		\$ cts.	\$ cts.	\$ cts.	\$ cts.
Prince Edward Island...	93,000	85,160 49	100,214 00	185,374 49	1 99
Nova Scotia.....	542,000	421,553 23	588,253 17	1,009,806 40	1 86
New Brunswick.....	440,000	306,060 00	99,186 00	405,246 00	92
Quebec.....	3,135,000	1,294,428 20	3,145,718 36	4,440,146 56	1 42
Ontario.....	3,711,000	1,833,187 50	4,922,819 65	6,756,007 15	1 82
Manitoba.....	717,000	396,864 31	1,150,498 00	1,547,362 31	2 16
Saskatchewan.....	939,000	596,408 00	1,933,040 00	2,529,448 00	2 69
Alberta.....	778,000	535,909 62	1,205,942 46	1,741,852 08	2 24
British Columbia.....	751,000	837,594 46	2,266,990 00	3,104,584 46	4 13
TOTAL.....	11,106,000	6,307,165 81	15,412,661 64	21,719,827 45	1 96

TABLE III
EXPENDITURE FOR GENERAL AND MENTAL HOSPITALS BY PROVINCIAL
GOVERNMENTS, 1937

Province	Population	Expenditure for General Hospitals excluding	Expenditure for Mental Hospitals	Total Hospital Expenditure	Per Caput Hospital Expendi- ture
		\$ cts.	\$ cts.	\$ cts.	\$ cts.
Prince Edward Island..	93,000	10,000 00	90,214 00	100,214 00	1 08
Nova Scotia.....	542,000	339,923 80	248,329 37	588,253 17	1 09
New Brunswick.....	440,000	20,288 00	78,898 00	99,186 00	23
Quebec.....	3,135,000	1,645,718 36	1,500,000 00	3,145,718 36	1 00
Ontario.....	3,711,000	1,457,099 88	3,465,719 77	4,922,819 65	1 33
Manitoba.....	717,000	289,565 00	860,933 00	1,150,498 00	1 60
Saskatchewan.....	939,000	623,040 00	1,310,000 00	1,933,040 00	2 06
Alberta.....	778,000	469,936 70	736,015 76	1,205,942 46	1 55
British Columbia.....	751,000	1,020,386 00	1,246,604 00	2,266,990 00	3 02
TOTAL.....	11,106,000	5,875,947 74	9,536,713 90	15,412,661 64	1 39

TABLE IV

EXPENDITURE FOR HEALTH SERVICES BY PROVINCIAL GOVERNMENTS
1937

Province	Population	Provincial Health Expenditures excluding Tuberculosis	Provincial Health Expenditures for Tuberculosis	Total Provincial Health Expenditures	Per Caput Health Expendi- ture
		\$ cts.	\$ cts.	\$ cts.	\$ cts.
Prince Edward Island...	93,000	46,968 86	38,191 63	85,160 49	0 92
Nova Scotia.....	542,000	117,823 91	303,729 32	421,553 23	0 78
New Brunswick.....	440,000	128,672 00	177,388 00	306,060 00	0 70
Quebec.....	3,135,000	736,112 20	558,316 00	1,294,428 20	0 41
Ontario.....	3,711,000	1,075,784 75	757,402 75	1,833,187 50	0 49
Manitoba.....	717,000	234,511 31	162,353 00	396,864 31	0 55
Saskatchewan.....	939,000	291,600 00	304,808 00	596,408 00	0 64
Alberta.....	778,000	217,461 14	318,448 48	535,909 62	0 69
British Columbia.....	771,000	262,162 08	575,432 38	837,594 46	1 12
TOTAL.....	11,106,000	3,111,096 25	3,196,069 56	6,307,165 81	0 57

TABLE V

PREVENTIVE HEALTH SERVICES AS PERCENTAGE OF TOTAL EXPENDITURE
FOR HEALTH AND HOSPITALS BY PROVINCIAL GOVERNMENTS, 1937

Province	Total Expenditure for Health and Hospitals	Preventive Services (estimated)	Per cent Prevention
	\$ cts.	\$ cts.	%
Prince Edward Island.....	185,374 49	13,060 00	7.0
Nova Scotia.....	1,009,806 40	124,526 08	12.3
New Brunswick.....	405,246 00	135,708 60	33.5
Quebec.....	4,440,146 56	407,713 93	9.2
Ontario.....	6,756,007 15	562,051 30	8.3
Manitoba.....	1,547,362 31	127,141 00	8.2
Saskatchewan.....	2,529,448 00	210,955 00	8.3
Alberta.....	1,741,852 08	168,285 03	9.7
British Columbia.....	3,104,584 46	184,049 80	5.9
TOTAL.....	21,719,827 45	1,933,490 74	8.9

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Canada - Social Security

SESSION 1943
HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

in joint session with the
Special Committee on Reconstruction and Re-establishment
and the
Senate Committee on Re-establishment and Social Security

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 13

TUESDAY, MAY 25, 1943

WITNESS:

Sir William Beveridge

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

TUESDAY, May 25, 1943.

The Special Committee on Social Security met jointly this day with the Special Committee on Re-construction and Re-establishment, and the Senate Committee on Re-establishment and Social Security, at 10.45 a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Bourget, Bruce, Casselman (Mrs.) (*Edmonton East*), Claxton, Cleaver, Diefenbaker, Donnelly, Fautoux, Fulford, Gregory, Gershaw, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), Macmillan, McCann, McGarry, McIlraith, Mayhew, Picard, Shaw, Slaght, Veniot, Warren, Wood and Wright.—32.

The Chairman introduced Sir William Beveridge and Lady Beveridge who accompanied him.

Sir William Beveridge addressed the Committees and answered numerous questions.

Lady Beveridge was asked to speak and briefly addressed the Committee.

Senator Lambert, Chairman of the Senate Committee on Re-establishment and Social Security, on behalf of the three Committees, suitably thanked Sir William and Lady Beveridge for their kindness in coming here and addressing them.

Mr. J. G. Turgeon, Chairman of the House of Commons Committee on Re-construction and Re-establishment, also expressed the Committees' appreciation. Sir William briefly replied.

The Committee adjourned at 12.20 p.m., to meet again on Thursday, May 27th, at 11 o'clock a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

MAY 25, 1943.

The Special Committee on Social Security met in joint session with the Special Committee on Reconstruction and Re-establishment and the Senate Committee on Re-establishment and Social Security this day at 10.45 a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Three committees, the Senate Committee on Reconstruction with an auxiliary Committee on Social Security, the House of Commons Committee on Reconstruction and the House of Commons Committee on Social Security are meeting this morning in joint session. We are to have the honour and the high privilege of hearing Sir William Beveridge, author of the notable report which he prepared for the British government. Sir William has given the greater part of his illustrious career to a study of welfare problems, and plans for the establishment of health and greater happiness for all mankind.

May I say to Sir William on your behalf how deeply we appreciate his presence here to-day, when he has interrupted what otherwise should be a necessary holiday, to give us the benefit of his experienced advice? We extend to him and to Lady Beveridge warm Canadian welcome.

It is my honour and pleasure to present to you Sir William Beveridge.

Sir WILLIAM BEVERIDGE: Dr. Macmillan, Senator Lambert, Mr. Turgeon, ladies and gentlemen, words fail me to say how much my wife and I appreciate the warmth of the Canadian welcome that we have had already here to-day.

We were told that we should like coming to Canada. We therefore hurried to come to Canada as soon as possible, as soon as we had fulfilled our necessary duties of courtesy to our first hosts in the United States.

I only wish that we could spend all our time in Canada and still have time left over to go back to other parts. We have been immensely happy in the few hours we have been here, and when I have got over the next half-hour I know I shall be very happy even in this room. Let me get over that next half-hour and talk to you and then invite you, if you care to, to ask questions of me.

I am particularly delighted to have the opportunity of addressing not one committee on social security, but three committees, and one of them which deals not only with social security but with reconstruction generally; because the point that I would most want to emphasize, is that social security or social insurance, which is the subject of the report which I made to His Majesty's Government in Britain six months ago, is only part and should be treated only as part of comprehensive programme of social progress, designed to make after this war a new Britain. I use the term "new Britain" as summing up all that we in Britain desire. We do not want a country other than Britain, we are very fond and proud of the Britain that we have known, but we do not want that Britain to be exactly like the Britain that has been in the past. It wants to be a new Britain. Sometimes when we are feeling rather discontented we emphasize the "new" more often than we emphasize the "Britain". Perhaps one party in politics emphasizes the "new" and another emphasizes the "Britain"; but all of them agree upon the "new Britain" as something the same and at the same time not just the same as we have had in the past.

To get those changes that we want—we want not only social insurance, but a comprehensive programme of social progress. Social insurance, the subject of my report, is an attack upon Want. It is designed to insure that for every citizen, on condition of rendering service while he can, there shall be a sufficiency of income at all times so that neither he nor any of his dependants are in want of the physical means of healthy subsistence. That is the gist of my report on social insurance.

It is a plan for securing that no citizen is in physical want through lack of insufficient income when he cannot earn, whether the interruption of earning is due to sickness, to unemployment, to any accident, to old age, or to any other cause. But, and this is one of the earliest paragraphs in my report, want is only one of five giants on the reconstruction road, one of five evils that have to be attacked in order to make the new Britain that we desire.

Want of sufficient income is only one of five giants and in some ways the easiest to attack and kill. The other four giants on the reconstruction road are: Disease, Ignorance, Squalor and Idleness. Let me explain briefly what I mean by each of these terms. Well, the meaning of Disease is obvious; and so are the means of attacking it. One cannot abolish all disease but one can attack it and one can diminish it. To attack and diminish this giant of disease means the development of comprehensive health services for all citizens, covering all their requirements. That also is, part of my report.

My report proposes not only insurance to secure cash income when earnings are interrupted, but, that in virtue of contributions made while one can earn, one should be entitled to get medical treatment of all kinds without a payment at the time of treatment. That is to say, the treatment that one needs, whether at home or in hospital, should be provided without charge at the time of treatment; there should be no economic barrier to the citizen being as well as science can make him.

I come to the next giant evil, that is, Ignorance. Attacking ignorance means a great development of education. It means for Britain more schools and better schools. It means to me, perhaps even more important, a great development of adult education, in order that citizens of Britain should not cease to learn when they go out to earn. There are many things which you can learn much better when you are older, because you can understand better when you are older. The development of education is a vital thing for any democracy, for two reasons. First, no democracy can afford ignorance among its citizens. Democracy depends upon the citizens casting their votes rightly, and that in turn depends upon education. Second, democracy implies equality of opportunity for talents. We cannot afford not to use all the talents we have in the country. We must get greater equality of opportunity for all people, both that we may use their talents and that we may avoid that unhappiness which comes when talents are unused. The greatest unhappiness in the world is having gifts which one cannot use, such as is brought about by restricting the able boy to work below his capacity. We must have greater equality of opportunity in education.

I come now to the next of these giants, which I call Squalor. I do not know what you would understand by that; but I understand by that the evils of bad housing and bad living conditions, which come about chiefly because of the disorderly growth of our great cities. We suffer now from our cities having grown too large, and having grown without order, without plan; this means, for large parts of the population, bad housing and bad living conditions, needless dirt, needless work for the housewife, excessive waste of human energy in travelling to and from work to the place of living. Dealing with squalor involves on the one hand better planning of the use of our town and country; on the other hand it involves a great development of housing, an immense programme of new building.

I come now to the last of these five giants, Idleness; by that I really mean prolonged unemployment. You will see that I distinguish between the evils of Want and Idleness. Want is something you can deal with by providing an income: you can guarantee that no people need starve, by providing an income when they are sick, when they are old, when they are unemployed, and when they are injured by accident. But providing an income to people who are unemployed for years and years together is a thoroughly inadequate remedy for unemployment, for the kind of unemployment that we had between the two wars. One must go beyond providing an income and ensure that that long unemployment does not occur. It is well to distinguish between the evil of want of the physical means of subsistence, which you can cure by social insurance and which is relatively easy to cure, and the much greater and more difficult evil of mass unemployment which corrupts people even if they have an income.

Of course, there are many things to be done in reconstruction outside the domestic sphere; we have to ensure peace and stop wars forever. In the domestic sphere, our program should be an attack on these five evils of Want, Disease, Ignorance, Idleness and Squalor, and I think I can assure you that something is being done about all those evils in Britain, just as I know that a great deal is being done in regard to all of them so far as you need to deal with them in Canada.

I came here to talk about Britain rather than about Canada, but I should just like to refer in one word to that remarkable report that Dr. Marsh has produced for you on social security. Dr. Marsh sent that to me. I got it in early March in Britain, and I was very much puzzled by it, because it referred to the Beveridge report; and therefore it presumably had been finished after the Beveridge report had been published. But I could not conceive how any document of that ability, scope and length could have been produced between the publication of the Beveridge report and the time when it was produced. Yet, I gathered that it was. Dr. Marsh seems to me to be a young man of extraordinary energy and has produced a report of first-rate importance. That report, although it is Canadian to the core, and in some important ways differs from my proposals—it differs in regard to workmen's compensation; it differs in regard to proposing a graduated scale of benefits and contributions instead of a uniform scale—it sets out a plan for giving security on the same full scale as was proposed for Britain in my report. I have no doubt you will not adopt the whole of it any more than Britain will adopt the whole of the Beveridge report. But Britain will adopt most of the Beveridge report, I am sure, with suitable adjustments and variations. I hope that something like Dr. Marsh's plan or something better than it, if you can improve it, will come into force in this country as I think that something like the Beveridge report, or something better than it, will come into force in Britain.

But is it not only for social security that we are planning in Britain. We have had this report of mine, which was discussed in parliament, and on which the government has now set up both a committee of the cabinet and a committee of officials to work out the details. One of the reasons the government of Britain have not finally committed themselves to the proposals of my report is because there are all these other evils to be dealt with; because they must weigh the expenditure for social security against the expenditure that may be required for housing, for dealing with squalor, against the expenditure that may be required for the development of education, and for dealing with idleness. The very fact that we are in Britain, I think, proposing to proceed on a broad front, is the reason the government, until they can see what all needs to be done, have said, "For the moment we cannot commit ourselves to any one thing until we know all that is wanted, and the whole cost of the budget." I am only

speaking from my own impressions; I have no authority to speak for the government, but I think you may take it, if there is any hesitation in Britain about my report, that it is only because the government want to go on a broad front and not because they do not want to have social security.

In Britain we have this proposal for dealing with want and disease. Those are two of the evils. They are in my report and they are under consideration by the government now, and under active consideration. Those of you who heard the Prime Minister speak on March 21 will realize that that consideration is very active. For dealing with ignorance and the development of education, there are plans being made by our Ministry of Education for squalor, we have both a Ministry of Works, which is concerned with housing, and a Ministry of Planning, which is concerned with planning the use of town and country.

The last of these five giants is Idleness. I am inclined to say idleness is the largest and fiercest of all the giants. This problem of maintaining productive employment is a problem of which we do not yet know the solution in Britain, nor, I imagine, do you know it finally in Canada. Yet it is not a thing to despair of. When people tell me that unemployment cannot be abolished, I say, "Well, at any rate it has been abolished twice in my lifetime: in the first world war and in the second world war." When people tell me I am over-optimistic in thinking unemployment in Britain after this war need not average more than eight-and-a-half or ten per cent and they think it must go back to fifteen or twenty per cent, I say to them: "At the moment it is less than one-half per cent; why must it go back to ten or fifteen per cent?"

Unemployment has been abolished twice in my lifetime, in two wars, and it is interesting to realize what are the conditions under which it gets abolished. It gets abolished broadly on two main conditions in war. One is that you have state planning to meet urgent needs. The community realizes there are certain needs which must be met if we are to survive; the need for arms of all kinds, ships, aircraft, tanks, food, all the necessities of life up to a certain limit must be met and plans made to meet those needs. The state takes over the direction of the whole of industry and production in order to meet those needs. That is one of the conditions on which unemployment is ended in war.

The second one is we get in war complete fluidity of labour and other resources. You do not get barriers to the use of men in the armed forces because they do not want to go into the armed forces or because people in the armed forces want to keep them out. You get in war the removal of all craft barriers all those barriers which in Britain at any rate, sometimes prevent the best use of our labour resources.

Those are the two conditions by which we are able to abolish unemployment, state planning and fluidity of labour and other resources. The fundamental question is how much of those conditions we must import from war into peace if we want to do the same thing or something like it in peace. Obviously we do not want to import everything of war into peace. Obviously in peace you must have a great deal more of private initiative and private enterprise in order to explore new needs. We do not want to have all our needs and all the things we want determined for us in peace as we do in war, but there must be some kind of plan for peace as there is a plan for war.

I believe that is clear, and equally I think there must be in Britain—I daresay it does not apply to you but it does apply to us in Britain—a greater fluidity of labour and resources, a greater readiness of people to turn to what wants doing instead of insisting on being employed in the ways in which they were employed the last time. I often say to the trade unions, and I think they would accept it, that nothing that any government in Britain had done between the two wars could have found employment for all our coal miners as coal miners, all our shipbuilders as shipbuilders, all our textile operators as textile

operators, because the world demand for these things had fallen off. These men might have been employed in other ways usefully, but not in their own trades. I think after this war we shall have to have a greater readiness in Britain—I do not think it applies so much to you—to change our jobs, to do what is wanted and not merely what we have been used to doing before. That is one thing that will be wanted. The other is that I think we shall in some way or other have to find a way of combining the responsibility of the state and of the community for maintaining employment with the use of private enterprise as a means of discovering new needs, of providing initiative and change in the community. I daresay different countries will have different solutions for that after the war, quite obviously they will. Presumably one of the united nations; Russia, will continue to organize her industry after this war very much as she has organized it in the past. Frankly I do not want anything like that for Britain. On the other hand I think that the United States will certainly undoubtedly try to rely very largely upon private enterprise. In the United States they still have a greater suspicion of government than we have in Britain. I think Britain will compromise between the two. I think Britain will use a combination of state enterprise and private enterprise. I do not know what line you will take. I suspect that like Britain you will be somewhere between Russia and the United States, possibly nearer the United States, possibly nearer Britain. I just do not know. There is no need for absolute uniformity in this at all. Circumstances in different countries differ.

I have got a report written on how to deal with want and disease but I have not yet got a report written on how we are to deal with this fifth giant of idleness. That is one of the things we have to discuss together. Having regard to what happens in war, to the fact we are able to abolish unemployment in war, to the fact that our total needs in peace are not less than what we need in war, although quite different in mind, I just do not believe that we cannot solve that problem if we are willing to pay the price.

To solve the problem of unemployment after the war and to maintain employment is, I believe, a good worth any price except war, and except the surrender of essential liberties. There are certain liberties which one in Britain would not surrender under any circumstances; liberty of worship, liberties of free speech and free writing; freedom in choosing one's job. Of course, choice of job has to be limited by the fact there must be a job available. You cannot have two people both choosing to be Archbishop of Canterbury because there is only one archbishopric to be filled, but freedom in choosing a job is an essential part of British liberty. I think that most important of all is freedom of association in unions and in political parties. To me a one-party state is not a democracy, whatever else it may be, because it does not enable me to change the government when I want to change it without shooting the governor. The essence of democracy is that one can change one's governor without shooting him. I do not like shooting him and the trouble is he is apt to shoot me first. Peaceful change of government is the essence of democracy and freedom to associate in new political parties is essential to secure this. Freedom to spend one's personal income is also an essential liberty. All these things we shall preserve.

I am not sure that I regard private enterprise in the sense of private ownership of means of production and employing other people as an essential British liberty. I think it is a very good device. It is not an essential liberty because, for instance, I have never had it myself. I have never owned a means of production except a fountain pen and I have never employed anybody except a gardener and yet I am as free a Briton as anyone can find anywhere in the world. The issue between state enterprise and private enterprise is not a question of essential liberties; it is a question of means, of method, of what is the most effective machinery for maintaining employment and raising the standard of living. Subject to the essential liberties that I have named, I

believe one can maintain employment in Britain; and I believe that in Britain we are determined to maintain employment and shall be prepared to take the necessary steps to that purpose.

All good things can be got for a price, but nothing can be got without a price; and I believe that the price of making a worthy new Britain probably is the same as it would be in Canada. There are two things that are necessary. First, we must be prepared to look ahead. In Britain one of our darling vices in the past has been that we did not like to look ahead; we trusted to muddling through. I hope now we have learned that you cannot do that with advantage. You do not do well in war if you have made no preparation for war; I think we have now come to realize that you cannot do well in peace if you have made no preparation for peace during war. Every war government—in your country, in my own country, and in all the countries of the United Nations—has two jobs: that of conducting the war to victory, and that at the same time of making plans and deciding on plans during the war for what is to happen when victory comes. We hear people saying: Let us win the war, and think about peace afterwards. That may be all right for people of my age. It is, I am sure, not what the young people who are doing the fighting will want, or will stand. I see streams of young men. They come through my hands at Oxford, many of them on the way here to train for the air force. They are ready to do all that is needed for victory. There is no question about that. But they are not thinking about victory as an end. They are interested in what is to happen afterwards. And we have to make plans for what is going to happen after, now.

The second part of the price for maintaining employment after the war is that there must be more international collaboration after the war than there was before it. That is one field. Obviously there must be international collaboration in preserving the peace after this war and the preventing of future wars. No one country can do that for itself. That can only be done by collaboration.

Another thing that no one country can do for itself is to maintain employment. That does not depend upon the way in which you organize your own industries. You can organize your industries in one way and the people of Britain can organize theirs in another way; and in the same way the people of the United States can organize theirs in another way, and the people of Russia can organize theirs in another way, and so on. However we organize it, all our industries will be affected by what is done by international trade. There must be consultation about international trade, about economic policy and trade policy between the different United Nations.

So that I would end by submitting three propositions: First, maintenance by social insurance of a minimum income to keep people out of want is vital, and in a sense the bed rock of all social reconstruction after the war; but it is only one element and it should be regarded only as one element in our programme. We must attack want, disease, ignorance, squalor and idleness; all of these, and not one only.

The second proposition is that plans for doing this must be made now and not left for consideration until after the war.

The third proposition is that the plans must be made in some essential things like consultation between the United Nations now, and in collaboration between them.

Those are the three propositions which I would submit to you. I submit them to you with great hopefulness. I know how much thought you are giving to this problem of social security in relation to other problems after the war. You are looking at the problem as a whole. You are clearly looking at problems now and not waiting until after the war. Finally, you have been good enough to invite me to come and speak to you of my suggestions. To me that indicates that you realize the importance and the necessity of international collaboration. Therefore I speak to you with hopefulness.

We must not regard this planning for what is to happen after the war as in any way a weakening or a diversion of our war effort. The year 1942 was the year in which we discovered this intense interest on the part of the British people in what should happen after the war, but it certainly was not a year in which the British people were at all backward in prosecuting the war. We can do the two things together. It is not weakening the war effort to think about what is to happen after the war; it has strengthened the war effort, because it shows to all our people—and above all to the young—what we are fighting for, and not merely what we are fighting against. That will strengthen our general determination, because we see an end beyond victory, not merely a victory which leads nowhere.

The CHAIRMAN: Sir William, what is the attitude of labour in Great Britain to your report, especially towards the extension of medical services to all?

Sir William BEVERIDGE: Well, the attitude of labour, I think I can quite safely say, is one of very strong support for practically everything in the report. It so happens that shortly after finishing my report I was married; and shortly after submitting my report there were three bodies in Great Britain, the trade unions congress and a party called the National Council of Labour, which is a combination of the trade unions congress, the labour party and of the co-operatives. They naturally wanted me to come and talk to them about my report. It so happened that the only possible day that they could fix was the day after my marriage, and I had been meaning to go away to Scotland—

Hon. Mr. MACKENZIE: Hear, hear.

Sir William BEVERIDGE: Obviously, they could not expect me to be separated from my wife on that day. But I told them that if she might come with me we would go and speak to the trade unions congress; and we celebrated our first day of wedded happiness by meeting the trade unions general council in the national council of labour in London, and my wife made a speech to them. After that—I do not know whether it was the outcome of that—they practically agreed and said that they wanted this report. I think I can tell you that the trade unions would have accepted the whole of this report, with certain modifications. In general, I can assure you that the trade unions congress and the labour party would have accepted in principle the whole of that report.

But, on the medical side, that proposal to have a comprehensive medical service for all and to have it lifted out of social insurance and administered by some other body was the actual proposition which the trade unions congress made to us.

I might go on further and say—if any of you are able to look at the evidence given to my committee by the trade congress, and by the various organizations that came before us—that if you were to compare what the trade unions congress said with what I proposed, you would find that they were practically all on the same lines. They wanted a comprehensive scheme allocating minimum benefits, all of which are in my report. Let me say that I have no doubt whatever of the strong support of labour for the whole of this report; indeed it was because they thought the government would not go far enough and fast enough in supporting this report that they voted in parliament against the government and against their own ministers. Labour is entirely, and I should say, absolutely solidly behind the essential principles of this report.

Mr. TURGEON: Sir William, I have two questions which I should like to ask on behalf of members of our own committee on reconstruction and re-establishment. This does not mean that other members may not ask questions if they wish. The first question is from Mr. Gillis of Nova Scotia and is as follows:—

Would Sir William Beveridge explain the difference between social insurance as proposed in the Beveridge report and the Marsh report and

social security as it is being administered in New Zealand at the present time? Which does he consider the most stable particularly with regard to financing?

Sir WILLIAM BEVERIDGE: I shall make the comparison first with New Zealand. New Zealand, under the Act of 1939, I think it is, has the most comprehensive scheme of social security in the world. I am not clear about Russia, and I shall leave Russia out for the moment, because they have a different economic system. Of any community with an economic system like Britain's New Zealand's scheme of security is much the most comprehensive; they are doing now practically all the things that I propose in this report. They have covered them pretty well as completely. The one important difference—of course, there are a lot of minor differences—but the one important difference is in the method of financing. In New Zealand the whole of the security is financed by a special income tax. That is to say, there is not a uniform contribution, there is no single flat contribution for everybody; everybody pays according to his capacity. I propose financing through a tripartite scheme of payments by the insured persons themselves through a tax on their wages, by the employer through a tax on his payroll, and by the state; and roughly my proposal is that one-quarter is to be contributed by the insured person, one-quarter by the employer and one-half by the state. Some people have asked: since you are going to have a compulsory tax why not do it all by income tax as in New Zealand? Why have a fixed contribution from everybody irrespective of his means? Does not that mean that the poor man is paying a larger proportion of his income for social security than the rich man? My answer is: that I am quite certain that that is what the people of Britain want. It adds to their sense of self respect to make a contribution irrespective of means. I do not believe that the people of Britain would have thanked me with anything like the same enthusiasm for a purely non-contributory scheme. None of the bodies representing the main bodies of British opinion, the ordinary insured person, the trade unions, or the friendly societies proposes abolition of the contribution.

Let me add another reason for having a fixed contribution. If you have everything simply coming from the state, apart from the fact that it looks like giving people everything for nothing, you set up a pressure simply to increase benefits irrespective of contributions. If nobody is paying contributions at all, everybody is going to ask for more and more benefits, and the taxpayer will find that out. If you have a system under which more or less a fixed proportion, say, one-quarter is raised in contributions, people will realize that they cannot get unlimited benefits without paying for them; and I believe that is an element of sound finance. In the last resort, there is not so much difference between my system and the New Zealand system as might appear; because although with my fixed contribution every man, whether his wages are £3 or £6 or £10 a week, pays the same insurance contribution, nearly every one pays also as a tax-payer. The £6 a week man or the £10 a week man or the £20 a week man pays more as a tax-payer, and we are nearly all taxpayers. But I do think it is a good plan to have a fixed contribution as well as taxation. That is the main difference between the British scheme and the New Zealand scheme.

There is another difference, and in this respect I think frankly that the British scheme is better than the New Zealand scheme, and it is this: in nearly all the New Zealand benefits there is some kind of means test—it is not a very stringent one, but to some extent there is a means test—and I do not think that is good. They do not apply that to pensions but they do apply it to sickness and unemployment benefits, and I think that is a pity.

Now, I come to the Marsh report. That is very much like my scheme. I do not know whether it is going to suit you; you must argue that out for yourselves, but if you should adopt it I should be delighted, because I should feel that you had a scheme very like our own scheme.

There are two main differences, and they are these: firstly, in place of a fixed flat rate of benefits and a flat contribution for everybody, irrespective of earnings, it is proposed by Dr. Marsh that you should have different rates of benefits and contributions, at any rate for all the employment risks such as unemployment and sickness, though not for pensions. In Britain our population is so homogenous and we are so industrialized; even agriculture has become so and is getting up so near to the wages of industry that we can, I think, have a flat contribution and a flat benefit. As you know, I am proposing for a man and wife something like 40 shillings a week as subsistence in unemployment, in pension and in sickness, and that applies to everybody, and I am suggesting a flat contribution of 4s. 3d. a week for the adult man in employment and a different rate for women, but there is no difference according to earnings.

Now, Dr. Marsh's report proposes a continuation of what you have in unemployment insurance, a graduated scheme of benefits and contributions related to earnings. There may be a very good reason for that, and it is not for me to advise you; but so far as I can judge there is a very good reason for that difference. You probably have greater differences in standards of living in this country and in different parts of this country than we have in Britain, and it is good, therefore, to have that variation.

Another difference between Dr. Marsh's report and mine relates to workmen's compensation for industrial accident and disease. In Britain our present scheme is that the employer is individually liable and is left to insure against his risks commercially; that is not a good system; practically everybody in Britain want to change it. In changing it I am proposing to make it a social service part of the general social insurance. You have now a different system from ours; Dr. Marsh says that it has worked well, and on the whole he assumes that it should not be changed.

I think those are the main differences between the two reports. Far more important are the points of similarity. Each of us proposes a comprehensive scheme covering all risks. Each proposes to give pensions not simply for becoming 65 years of age as at present but only on condition of retirement and to increase the pension if retirement is postponed. You are proposing to have universal medical treatment and children's allowances. If you do all this you will have not a copy of the British scheme, but the Canadian counterpart of the British scheme. Each proposes pensions at a flat rate for all, enough for subsistence.

MR. TURGEON: The second question of our committee is by Mr. Castleden and is as follows: "Is it possible for private industry, as we know it, to provide a sufficiently high level of employment necessary for social security of the people? If not, what in your opinion is the alternative?"

SIR WILLIAM BEVERIDGE: This is looking for the last page of the book of which I have written as yet only the first page: on how one can maintain employment. It is not impossible for private industry to maintain a sufficiently high level of employment. I should say that if we could get back to the levels of unemployment that we had before the first world war it would be possible. That was done by private industry. The unemployment that we had in Britain before the first world war was not more than could have been covered thoroughly by unemployment insurance. When we introduced unemployment insurance in Britain in 1913-1914 we calculated that a benefit of not more than fifteen weeks would cover all but about 5 per cent of the total unemployment. These were golden days. If we could only get back to them, and if private industry could get us back to them, then I do not think you need more unemployment insurance for the unemployment that remains. So it is not impossible for private industry to maintain a sufficiently high level of employment. But if you ask me whether private industry is likely to be able to do this in future,

my answer is not so clear. Frankly I am not very hopeful that private industry will by itself get us back to that, but I do not want to give a definite answer. I am only exploring, myself, how much private industry can do and how much the state must come in to help private industry to-day.

Mr. MACINNIS: In reply to the Chairman's question Sir William told us that the Labour party and the Trade Union Congress and the Co-operative movement, in so far as their association, the General Council of Labour is concerned, have all endorsed his report. I understand there is considerable opposition to the plan in Great Britain. What sections of society does that opposition come from?

SIR WILLIAM BEVERIDGE: I do not know; I cannot find it. Of course, you would not expect the British to swallow any medicine whole; they would not be British if they did. A lot of them want things changed in this report. I think there is only one body of people—and seriously I do not think they count—who really are violently opposed to the whole plan, and these are the individualists, the extreme individualists, the people who hate all government as such. I think they just represent about 1 or 2 per cent in Britain. They do not count. There are, of course, certain interests, the industrial assurance companies, whom I attack in my report. Quite reasonably they defend themselves by attacking me. The industrial assurance companies do not go about objecting to the report as a whole; they rather say the report on the whole is excellent except those parts of it which refer to them. I have no doubt they are using their agents to make people unhappy about the report. Then there are people who do not think the report gives enough to the old age pensioners. My proposal for reasons which I give in my report is that the full rate of old age pension should not materialize for twenty years. New Zealand has a similar plan in regard to its pensions. Many people think that we ought to give the full pension immediately and I am quite certain that the Labour party will propose to get it not necessarily immediately but much earlier than 20 years. But these are differences on points of detail to the Report as a whole. I have not found any serious opposition in Britain. Whenever a by-election takes place the government candidate finds himself sooner or later saying that he wants the Beveridge report as soon as possible—

The CHAIRMAN: And he wins?

Sir WILLIAM BEVERIDGE: No; he says that he wants it as soon as possible and the other man gets up and says, "I want it now." Then sometimes the government candidate gets in by a small majority and sometimes the other man gets in by a small majority. Honestly, I do not think I am exaggerating when I say I do not think there is any serious, any real opposition at all. There are people who are afraid that we cannot afford it and are hesitant. You all know what the Prime Minister said. He said in his broadcast: "I and all my colleagues are firm believers in social insurance for everybody from the cradle to the grave, but," he said, "we want to see where all this has to fit inside the budget. We have to find money also for education, housing and other things. We want to see where the money is coming from."

Mr. GERSHAW: I wonder if our honoured guest would express an opinion on the details of the medical services. For instance, what position will the doctor be in? Will he practise from his own office or from some health centre, and how will he be paid for his services, by fee or salary or on a capitation basis?

Sir WILLIAM BEVERIDGE: That is a very important question, but it is not actually settled in my report and it is not settled yet. What my report says is this: that medical treatment ought to be paid for on a social insurance basis; that is to say, paid for by contributions put in in advance and not by charge

when the treatment is given. That is common sense, because when a man falls ill he is apt to lose his income and this is not a time when he ought to have doctors' bills to pay, he ought to have no charge for treatment. The citizen should pay for his treatment by contributions and by taxation beforehand and not by paying doctors' bills. But that does not settle how the doctor is to be paid or to be employed. It would be quite consistent with my proposals for a doctor to write out his bill every time he visits a patient and send it to a central office instead of to the patient. It would be quite consistent for the doctor to be paid on the panel system that we have at present in Britain. It would be equally consistent with my plan to have a salaried medical service. But the decision between these possibilities is not made in my plan. I have left it open for further discussion. If you ask me what is going to happen I can only say it is now being discussed between the government and the medical profession. The government has said, "We accept the principle of comprehensive medical treatment for everybody." They have accepted that principle. They are discussing with the doctors how this treatment should be organized. The doctors in Britain are, I am sure, completely prepared for a social insurance basis for medical treatment. While my report was being prepared the British Medical Association had a planning commission which made a report proposing that social insurance for medical treatment should apply to 90 per cent of the population; they wanted to keep an income limit of £420 a year, keeping 10 per cent out of insurance. When that proposal came before the British Medical Association as a whole, somebody moved an amendment to drop the income limit and apply insurance to 100 per cent. That amendment was carried by a small majority. You may take it, the doctors in Britain are perfectly prepared for social insurance on health. As to the other point in question, the B.M.A. planning proposal was for the setting up of health centres for medical treatment so that doctors could work together in groups and give specialized treatment. Of course the doctors attach importance to free choice of doctors by patients and patients by doctors. It is quite possible under my scheme to have that, and I have no doubt we shall have that. There is also a difficult question as to how the hospitals should be organized. We have, as you know, a great system of voluntary hospitals and public hospitals; and there is a great deal of discussion as to whether the voluntary hospitals are to be preserved as voluntary hospitals or whether they should all be put under the local authorities. I should say, generally, that the doctors in Britain are prepared for a great development of social insurance in relation to treatment. I do not think they want to have a salaried medical service; but I am not sure how strongly they would oppose a salaried medical service if it were national rather than under the local authorities. There is nothing settled about that, and I cannot say exactly how it all will be done.

MR. FULFORD: I wonder if Sir William could tell us the per capita cost of complete medical and dental service and what the cost in Britain would be.

SIR WILLIAM BEVERIDGE: No, I cannot. In my social security budget I estimated—and this is a very rough estimate—that the total amount being spent on medical and dental services was in the neighbourhood of £170,000,000 a year; that is, having regard to the population, about £4 per head. That includes everything. It includes what people are paying to their doctors for private treatment. It includes, of course, all the institutions for the mentally infirm and also the hospitals. It includes all the panel payments, and the dental treatment and so on. I say at once, that I think that is not a very firm figure. It is very difficult to estimate; but it is in that neighbourhood of £170,000,000 or £180,000,000 a year. That is the whole cost. My proposition is that, for social insurance, something like one-quarter of that should come from the contributions of insured persons, the rest being found by national taxation or local taxation; that is, the rates.

MR. BLANCHETTE: Would our distinguished guest care to give any comment as to his appreciation of children's allowances in any plan of social security?

SIR WILLIAM BEVERIDGE: I am very glad you asked that question, because children's allowances are the most revolutionary thing in my report, and they have been accepted in Britain. I propose children's allowances for two main reasons in my report; meaning by children's allowances, allowances paid both when the responsible parent is earning and when he is not earning, not simply paid when he is on a benefit but also when he has wages. I propose that for two reasons. The first is that without children's allowances you cannot abolish want. Wages may be enough for a man, wife and one child, or for a man, wife and two children. But when you get up to really large families, we find in Britain that there are appreciable numbers of cases where the wages are not enough for the size of the family. Poverty in Britain before the war was due to two causes. My whole report starts with the diagnosis of poverty. It was due either to the interruption of earnings or a man having too large a family for his wages. About five-sixths of all the poverty was due to the interruption of earnings—I mean through old age, sickness, unemployment and the rest of it—and about one-sixth was due to cases where the man was in work but he had too large a family for his wages. We do not believe that Britain can get on unless there are a substantial number of large families. Some people will have a small family or none. Unless we can get an *average* of nearly three children born to a family the British race will diminish and finally die out. Therefore there must be some large families and we want some large families. In order to abolish want, you have got to have children's allowances. That is one thing. The secondary reason is that if you give allowances for children only when people are unemployed or sick, you will sometimes have cases where people have as much money when they are sick or unemployed as they can earn, or even more. That is a bad situation. It is wrong that a man should be getting more when he is without work than when he is working; yet you cannot avoid that if you have a wage system which takes no regard to family responsibilities. There are quite a number of other reasons for children's allowances such as its effect upon the population and the quality of population which I will not go into now. But the two reasons in my report are those. Until recently there was considerable opposition to children's allowances on the part of some trade unions. But at the last Trade Union Congress, in September last, they accepted children's allowances. It has been accepted by the government. The government propose to give less in amount than I have proposed but they have accepted the principle. I think you may take it that it will be adopted. I should be very much interested to see whether or not you adopt it in this country. I hope you will, because I believe it is a good thing; but it is a bigger change than anything else in my report. There is nothing new in social insurance. We all know about it in Britain. We all agree upon it. The thing upon which we have changed our minds in Britain—and I think we have changed it—is children's allowances.

THE CHAIRMAN: These questions are all very interesting, but I would remind the committee that Sir William has an engagement very soon. If you make your questions very brief, we have time for perhaps three or four more.

DR. MCGARRY: Sir William, I should like to direct one question to you and it will call for but a brief answer. Granted that this social security plan will be accepted by the government, and arrive at the legislative structure, is it the general conception that there will be a waiting period, or will these benefits be put into effect right away?

SIR WILLIAM BEVERIDGE: I do not think it will be put into effect until after the war, if that is what you mean. You are not thinking of the waiting period at the beginning of unemployment or sickness?

Dr. McGARRY: No. You say "after the war"?

Sir WILLIAM BEVERIDGE: My proposal is, that it should only come into force after the war. The one matter on which it is possible that we might make an exception and proceed earlier is children's allowances. Quite a number of people think we ought to start those at once. But my whole scheme was for after the war.

Mr. KUHLMAN: Mr. Chairman, may I ask Sir William if it is fair to say that in so far as his proposals are concerned and the source of funds to support them, they do not involve more than a redistribution of the existing financial income? Then as a further question, would he agree that the legitimate purpose of an economic system is the provision of an abundance of goods rather than an abundance of jobs?

Sir WILLIAM BEVERIDGE: What is in my report for social insurance is a redistribution of income and a redistribution of purchasing power, both horizontally and vertically. Let me explain what I mean; I mean horizontally as between the times of earning and not earning. I want to make sure that everybody has an adequate income when he is not earning as well as when he is earning. For that purpose I take part of his earnings, when he is earning, in contributions and transfer it to the time when he cannot earn. That is redistribution horizontally. There is also a redistribution vertically by taxation. It is a redistribution of purchasing power, because it is no good having goods unless you have purchasing power. Without purchasing power you do not abolish want. You must see that there is purchasing power available at all times up to a minimum in order to abolish want. Of course, I agree that the essential is the production of goods. The object of that is secured by maintaining productive employment. That is dealing with the giant, idleness. This report deals with the giant, want. Both these things are needed and you cannot do without either of them. You cannot do without social insurance to redistribute income. You cannot do without productive employment to see that there is enough total income to be distributed.

Mr. TURGEON: I have one more question from our committee asked by Mr. Paul Martin: Is not your scheme predicated upon the maintenance or stabilization of the price structure? Would you agree that the stabilization of the wage structure is not necessary to your scheme?

Sir WILLIAM BEVERIDGE: I think any economic system which uses prices at all must assume, indeed not absolute fixity of prices, but reasonable stability. You cannot reckon with counters which alter their value very largely every day. I think we have in Britain a general policy of stabilizing prices so far as possible. The Chancellor of the Exchequer said he hoped to be able to keep prices after the war to something like thirty per cent above the pre-war level. My scheme is based upon something of that sort. When you come to stabilization of wages I do not contemplate that after the war we shall have anything like compulsory arbitration of state fixing of wages. I am sure that the trade unions would not accept that and I do not think they need accept that. I do not think you need stabilize wages in a sense to prevent them from rising if production rises. Of course, you cannot have wages rising if production is not rising and prices remain stable, but I do not urge stabilization of wages because I see no limit to the possible improvement of wages in Britain as our production improves.

Mr. BLACKMORE: Is it possible for anyone who is not a member of one of these committees to ask a question?

The CHAIRMAN: Surely.

Mr. BLACKMORE: I should like to ask two or three questions of our distinguished guest. The first one has to do with the conditions which he found obtained during the war. The first one was that there was a planning of production during the war.

Sir WILLIAM BEVERIDGE: Yes.

Mr. BLACKMORE: Is it not equally true that during the war there is a planning of distribution, that is, we have no more worry about markets? What we are unable to consume ourselves we let the enemy consume, and is not one of our major problems in peace the provision of an equally effective method of distribution so that in so far as we are not able to use our goods we are able to dispose of them in some other way? Would that not be worthy of consideration?

Sir WILLIAM BEVERIDGE: I am not quite sure that I follow the point. Others seem to. Perhaps I might get some enlightenment.

Mr. BLACKMORE: I was unable to hear.

Sir WILLIAM BEVERIDGE: I say I am not sure that I follow the point so if I do not answer you correctly you will tell me.

Mr. BLACKMORE: One was the method of disposing of goods. How are you going to sell goods? How are you going to get markets? Even if the government did have a planned production during peace how would it sell the goods?

Sir WILLIAM BEVERIDGE: My planning of production means that the state should ascertain the needs. There are needs in peace as there are in war. There are needs for houses, for schools, for hospitals, for furniture, clothes, travel and every kind of need. That is true in peace as in war. In peace we shall be supplying our own citizens with goods rather than as in war supplying the enemy with beds, but I do not think that there is any need for the state in peace to control distribution in the sense in which it controls distribution in war by rationing, and so on. I do not think that is necessary. I do agree we have to find markets for all we produce in peace. I simply say the needs of peace are unlimited and it is only a question of organizing to meet them.

Mr. BLACKMORE: There is no question, Mr. Chairman, about the need being there. The question is: Are the people who need able to buy? If they are unable to buy they certainly cannot satisfy their needs.

The CHAIRMAN: Before we adjourn I am going to ask Lady Beveridge if she will kindly address the meeting.

LADY BEVERIDGE: Ladies and gentlemen: I am very much honoured that you should have allowed me to come here to-day, and still more that you should ask me to say a few words to you. You would not expect me to go on talking about my husband's social security plan although, in fact, it contains a number of regulations about the status of women in our country that are novel and interesting, and that have pleased and gratified the women of our country very much. I should only like to endorse what William himself has said about our great delight in coming here and the wonderful welcome you have given to us in your beautiful city. Last night I was in a gathering that consisted almost entirely of Scots and I imagine from some of the names that I have heard this morning that there are quite a number here, too. I only want to thank you all from the bottom of my heart for your kindness, and I know I speak for my husband, too.

The CHAIRMAN: Senator Lambert, please.

SENATOR LAMBERT: Mr. Chairman, Sir William and Lady Beveridge, ladies and gentlemen: The demands upon our distinguished guests require that we draw this discussion to a close. It is my happy duty to express to a certain extent our appreciation of their presence here to-day. On behalf particularly of the committee of which I have the honour to be chairman, and also of that branch of parliament which I represent, I should like to say to them both how deeply we appreciate their being with us to-day. We have looked forward to their visit with a great deal of anticipation, and I am sure that their presence with us this morning has met and fulfilled all our expectations. I am sorry particularly that these questions which were developing should have been

called to a stop. As a matter of fact, this meeting was assuming more and more the form of many occasions of meeting in this room, and as a frequent attendant at those meetings I have often wondered just what it would be like to sit on this side of the table and look into the faces of those who are asking questions.

I might say, Lady Beveridge, that in the chair which you are occupying to-day there usually sits on such occasions a very distinguished gentleman whose duty it is to sum up the discussions at the end of the meetings. I am sure if he were here to-day he would agree that the average quality of the discussions had been considerably elevated and the atmosphere of this room had been greatly enriched by the contribution of Sir William and yourself. I might also say coming from that other House which has been so often referred to in admiration by so many, that we appreciate greatly the honour of being here in association with my friend, the Chairman of the House of Commons' committee and his members. I am sure that in future we shall refer to that other place with due restraint. I can only add, Mr. Chairman, that it has been a great privilege to be here.

Mr. TURGEON: Sir William and Lady Beveridge, Senator Lambert and Mr. Chairman: time presses, and I will say nothing whatever, except to express the deep appreciation of the members of the House of Commons Committee on Reconstruction, and of all others who are present this day, to you, Lady Beveridge, to you, Sir William, for yourself and for what you have given us to think over. I am positive that your earnestness will add spirit to our committee, and that our activities will be increased because of your visit.

I thank you.

Sir WILLIAM BEVERIDGE: I have only to thank you very much indeed, for your attention and for your questions. I do find questions most stimulating and most helpful, and I never have gone to a meeting in which questions have been asked that I have not gone away, I hope, a wiser and better informed person. I certainly have learned to-day. I naturally rather wish, after listening to Senator Lambert, that I could have the opportunity of seeing this room in one of its more normal sessions; sitting, perhaps, in that corner over there where Mr. Blackmore is. If, as seems to be suggested by Senator Lambert, to-day's proceedings lead to the Senate having a greater opinion of the House of Commons or, the House of Commons of the Senate, I shall feel that I have done something for political security as well as for social security.

Thank you.

The committee adjourned at 12.23 o'clock p.m. this day to meet again tomorrow, Wednesday, May 26, 1943, at 11 o'clock a.m.

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SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 14

THURSDAY, MAY 27, 1943

WITNESSES:

Dr. E. Stanley Ryerson, Assistant Dean, Faculty of Medicine, Toronto University, and Director of the School of Physical and Health Education;

Dr. A. S. Lamb, Director, Department of Physical Education and Director, School of Physical Education, McGill University;

Mr. A. A. Burridge, Physical Director, McMaster University, Hamilton, Ont.;

Captain Ian Eisenhardt, Department of National Defence, Ottawa.

OTTAWA

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PRINTER TO THE KING'S MOST EXCELLENT MAJESTY

1943



MINUTES OF PROCEEDINGS

THURSDAY, May 27, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Mr. J. A. Blanchette, the Vice-Chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Bruce, Casselman (*Mrs.*) (*Edmonton East*), Claxton, Coté, Donnelly, Fulford, Gershaw, Gregory, Howden, Hurtubise, Kinley, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), McGarry, Picard, Slaght, Warren, Wood—22.

At the request of the Chairman, Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, introduced the following witnesses:

Dr. E. Stanley Ryerson, Assistant Dean, Faculty of Medicine, Toronto University, and Director of the School of Physical and Health Education;

Dr. A. S. Lamb, Director, Department of Physical Education and Director, School of Physical Education, McGill University;

Mr. A. A. Burridge, Physical Director, McMaster University, Hamilton, Ont.;

Captain Ian Eisenhardt, Department of National Defence, Ottawa.

The witnesses were called, examined and retired.

Appreciation of the evidence submitted was expressed by Mr. Kinley and Mr. Bruce.

The Chairman thanked the witnesses and the Committee adjourned at 1.00 o'clock, p.m., to meet again on Friday, May 28, at 11.00 o'clock, a.m.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS

May 27, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Deputy Chairman, Mr. J. A. Blanchette, presided.

The DEPUTY CHAIRMAN: I understand that the briefs to be presented this morning are to be on the subject of physical fitness, and that the speakers are to be Dr. Stanley Ryerson, Assistant Dean, Faculty of Medicine, Toronto University; Dr. A. S. Lamb, Director of the Department of Physical Education and Director of the School of Physical Education, McGill University; Mr. A. A. Burrige, Physical Director, McMaster University, Hamilton, and Captain Ian Eisenhardt, Department of National Defence. I will ask Dr. Heagerty to kindly present these gentlemen.

Dr. HEAGERTY: Mr. Chairman, Mrs. Casselman and gentlemen, I have the honour to introduce to you first this morning, Dr. E. Stanley Ryerson. Dr. Ryerson is Assistant Dean of the Faculty of Medicine of Toronto University, Director of the School of Physical and Health Education and Professor of Health Education. Dr. Ryerson has been engaged in the work of health education for many years, and it was as a result of his suggestion that a three-year course in physical and health education at Toronto University was established, to train teachers and specialists in health and physical education. He is the author of many papers on physical fitness. I would ask Dr. Ryerson to stand.

Dr. A. S. Lamb, of McGill University, has been in charge of the Department of Physical Education since 1912. At the present time he is Director of the Department of Physical Education as well as Director of the School of Physical Education. He is Honorary President of the Quebec Physical Education Association and was the founder of the Canadian Physical Education Association and president for a period of six years. I would ask Dr. Lamb to stand.

Next is Mr. A. A. Burrige, who is Physical Director of McMaster University at Hamilton, Ontario. He has been engaged in teaching physical fitness, has acted in a directional capacity for twenty years or more and is a recognized authority in the field of all that pertains to physical fitness. I would ask Mr. Burrige to stand.

Then Captain Eisenhardt. It really is not necessary for me to introduce him to this audience, he is so well known for his work in the field of physical education and particularly in the "Pro-Rec." effort in British Columbia. I may say that these gentlemen have come here at their own expense to help us in this work that we are doing.

The DEPUTY CHAIRMAN: I will call on Dr. Ryerson.

Dr. E. STANLEY RYERSON, *called*.

The WITNESS: Mr. Chairman, Mr. Minister and members of the committee, I appreciate very much the honour you have done me in inviting me to appear before you here to present my views, with the object of trying to help you develop the idea of physical fitness throughout Canada. It is a thing that is very dear to my heart and a thing that I am delighted to see the government is taking up. I hope that it will reach some fruition. During the winter I happened to be chairman of a committee at the University of Toronto, at the request of Dr. Weir, in connection with rehabilitation after the war; and I prepared a report in connection with what, in my opinion, should be developed in medical education

at that time. The outstanding feature of it, to my mind, is the introduction into that course of the teaching of health. I will read a section with reference to that, and my arguments, and show where physical fitness comes in, in relation to the picture of health as well.

"Man has been slow to recognize the fundamental significance of health, which is a positive condition, something more than the negative state of no illness or freedom from disease. Preventive medicine is one of the great advances of recent years, but it is time now that medicine took another step forward and initiated an age in which it teaches man the art of a health which can be enjoyed as a positive possession.

"Nature has endowed man with a body of inconceivably perfect structure, and a coordination of function which is still far beyond our comprehension. It is the most adaptable organism of all living creatures, and by its activities can be a perfect vehicle for all his higher mental and spiritual life. The healthy balanced body, together with all those other aspects of man's personality, emotional, moral and spiritual, constitute the whole man."

The British Medical Journal published the report of the Medical Planning Commission in Great Britain on June 20, 1942, in which the objects of reform in medical practice and provision are laid down as follows:

"The commission has adopted for the purpose of its discussion the following broad definition of the objects of medical service in this country—

- (a) To provide a system of medical service directed towards the achievement of positive health, the prevention of disease and the relief of sickness."

In other words, positive health has been recognized by the Medical Planning Commission in Great Britain as an important factor in medical practice and the phrase "the achievement of positive health" might be inserted before "the prevention of disease" in the line before the last in Paragraph 27 (1) "Benefits" of the Draft Health Insurance Measure. I might point out that this Report has also been followed up by an article by the Regius Professor of Medicine at Cambridge University, Dr. John A. Ryle, who is Consulting Physician to Guy's hospital, in London, and has recently been appointed Professor of Social Medicine at Oxford University under the Nuffield fund. He wrote an article on December 26, 1942, for the British Medical Journal, on what he called "The Science of Health." This is an address to the medical students:

"For my annual wartime lecture I have chosen on this occasion a subject which, curious though it may seem, finds no special place or mention in the curriculum. Medicine is primarily concerned with the observational study (with a view to its relief) of disease at the bedside, in the consulting room or clinic, and in the laboratory. Disease also had its own science of pathology, which is concerned with the more intimate laboratory investigation of its causes, processes and consequences. But, notwithstanding that the study of health would seem to be the proper preliminary to the study of disease, we find no counterpart to medicine, no parallel observational science devoted to the fireside or field-side or laboratory study of health. Nor is there a science comparable to pathology which deals with the more intimate causes, processes and consequences of health.

"Hygeia, the daughter of Aesculapius, was the goddess of health, a subject in which the Greeks were intensely interested, and hygiene originally meant the science of health; in modern usage, however, it has come to convey the narrower meaning of sanitary science. Physiology and anatomy, it is true, concern themselves with some of the processes and attributes and supply some of the standards of health; but as a rule they have little to say of its outward manifestations, of what may even be called its 'symptoms and signs' or of that elaborate coordination of functions by which it is constituted. They touch scarcely at all upon its causes and consequences.

"Please do not think that I wish to extend or complicate the curriculum, but it is surely an omission that so little attention has been paid by the students of disease and their teachers to that state from which some deviation or departure must occur before the existence of disease is recognized. And so, because it has a bearing on your future tasks and outlook, I suggest that we give our minds to the subject of health and how it might be better regarded and how more usefully observed and studied. Let us begin by asking ourselves five questions: (1) What is health? (2) Why is it important to know more about health? (3) What are the principal symptoms and signs or other criteria of health? (4) What are the causes and consequences of health? and (5) How in the future can we make a better contribution to the promotion and maintenance of health?"

In the publication "The Science of Health" by Florence Meredith in 1942 there is published a graph which I will show you in a moment, in which it appears that "in large groups of unselected individuals there will be some, perhaps 10 per cent, who are virtually well. At the bottom of the list of those who are not well is the relatively small number, 5 per cent, who are actually ill and disabled, with another 5 per cent in a condition in which they should not work. Between these two extremes are those 80 per cent who are neither really well nor frankly sick. They are unfitted for the fullest and most efficient activity for their own satisfaction and for service."

I had a graph prepared of this size to show the relative percentages in graph form, which may make this a little more clear to you. Here is the 100 per cent as laid down in "Science of Health" by Miss Meredith, with the 10 per cent here of completely sick. These are really either sick or convalescent. Here we have the 80 per cent semi-well and only 10 per cent of the people actually are in Class A, in perfect health.

I gave a paper in 1941 on Human Health and its Assessability, and it is along the same lines. I also classified the people. Under class E are the people who are actually "sick". In class D there are about 30 per cent of the people, whom I have classified as "loss of health". I will explain that in a moment. Above that are 30 per cent who are either in a low degree of health or poor health, 20 per cent in average health and 10 per cent in excellent health—the same 10 per cent that we have above. In other words, I have taken this part of the group, the 40 per cent, and divided it into two groups. Class A is an individual who is in perfect condition, physically, nutritionally, mentally and every other way. Below him are the Class B men, of whom there are about 20 per cent, who are in good average health and who can carry on in their daily lives; but by proper attention to their health, either physically, nutritionally or mentally, many of these men in Class B can be raised to Class A. Then we come to the third group. I have classed it as "poor" health, who are barely able to carry on. They are in such poor health that in any one of these three ways, physically, nutritionally, mentally or emotionally, they are merely dragging themselves around from day to day; they very quickly break down and get into trouble. Then we have 30 per cent below that, which I speak of as "loss of health," implying that health is a positive thing which you can lose.

By Mr. Slaght:

Q. I did not catch what country this test was made in?—A. It is my own conception here in Canada. Here are some actual figures I have built up. It is my own conception which I built up, before I saw the chart of Dr. Meredith of the different degrees of health as far as the people are concerned. Below are shown the categories of Canadian recruits—and there is the 40 per cent which corresponds relatively to number one—the unfit as far as service is concerned, then the lower categories as far as service is concerned. Those were the categories of the first 50,000, as was published in the Canadian

Medical Journal, and of the 209,000 as was published in the Toronto Saturday Night. In both those instances they have in the neighbourhood of 40 per cent who are not perfectly fit when they take them into the army. Even this group that were taken into the army were unquestionably not physically fit. The first thing they do with them when they get them in the army is to give them physical training and put these C-men up to B or A. That is as a result of the life they lead. Then "loss of health" is a quite correct description, because a person may lose his health and that may be the only thing that is the matter with him. He loses his strength, has little appetite, little desire to do things. He is irritable. When such an individual is examined, in certain instances, in the 15 to 40 age group, he is found to have tuberculosis; in other words, the first early symptoms of it are those only of a loss of health.

By Mr. Howden:

Q. Did you say the percentage?—A. No. I did not say the percentage. I say many. What I am trying to point out is that a man may have active tuberculosis and no other symptoms than simply being tired out and being unable to carry on. We are finding and catching these cases by X-ray of the chest which was done with the employees here in the dominion service. By this method we last year picked up six cases of tuberculosis among university students. The year before we picked up approximately the same number. In many of these instances they have not even lost their health. Many of these fellows did not realize they had any disability. When you come to the older individual, over forty, the most common cause of "loss of health" is the onset of internal cancer—cancer of the stomach, cancer of the bowel or some part of his body. All the symptoms he has in the early stages are simply that he has not got the ability and strength to carry on. He loses weight and he becomes emotionally upset. The only way in which we are going to get this group to the doctor in the early stages of this disease is by getting people who are well to have a regular health examination and not wait until they are sick before they go to the doctor. The point I wanted to make with this upper 60 per cent group is that you can categorize men into the various categories, A, B or C and that those in B or C can be raised to a higher level by the application of the general principles of a physical fitness program.

By Mr. Kinley:

Q. Are there not a lot of these men in the lower groups because of the loss of a member and not because of ill health?—A. Oh, yes. But this is broad.

Q. There are many men who have a finger off or something?—A. Oh, yes. But as a matter of fact, when you come to read the classifications of those I have spoken of, it is surprising how many other things there are.

By Mr. Howden:

Q. You made a very general statement there to the effect that a large proportion of these men turned out to be cancer cases.—A. No; not a large proportion. I say a person who has cancer has the onset of symptoms of loss of health only, in its early stages.

Q. I understood you to say that the preponderance of these men had cancer?—A. Oh, no. I am not extravagant. I am merely trying to draw attention to the point of view.

Q. I was wondering how the presence of cancer was brought out in these early cases?—A. Merely from my own experience of cancer and seeing them in the hospital. I think Dr. Bruce can confirm that very fact. Many of these early cases—unfortunately too many of them do not catch it in the early stages—do not think there is anything more than loss of health. They go away for a holiday and try to build themselves up for months, and not being able to do so, they go

to a doctor who finds they have cancer which has become too far advanced for treatment to be applied successfully.

By Mr. Lockhart:

Q. Under the pressure of present employment, is this condition becoming more evident at the present time?—A. You mean that there are more people with loss of health?

Q. More people that are being revealed as being semi-healthy.—A. No. I do not think that is the case.

Q. I understood that it was.—A. I have not any figures on that.

By Mr. Wood:

Q. Has occupation anything to do with these various categories?—A. Industry is taking cognizance of this fact, that men have to be kept healthy, for the industrial physicians are brought in to examine the men when they are employed. One of their chief functions is to try and keep the men well after they have been taken on.

Q. The part I wish to have explained is this. You suggested that nutrition had a great deal to do with the condition of physical fitness?—A. Yes.

Q. As a rule, farmers get plenty to eat. Are they in any better categories?—A. No; because the farmer does not know what to eat. It is strange. I can say that neither does the man in the city. Why have they got the advertisements in the street cars describing the diet that we should observe? In 1943 we are just beginning to have an idea of what a well-balanced diet is.

By Mr. Slaght:

Q. Would that apply to drinks as well as food?—A. That is part of it.

With reference to physical education itself, I suggest as follows:—

“There is an urgent demand throughout Canada for individuals, both men and women, who have a sound knowledge of health education and physical education and are capable of taking positions either as—

Teachers in the secondary schools.

Teachers in private schools.

Teachers in universities.

Directors in Y.M.C.A.'s or Y.W.C.A.'s.

Physical education directors, instructors or supervisors, beach and swimming pool patrols in urban playgrounds, community recreation centres, industrial and commercial sports, games and recreation clubs, summer camps.

During the war, all branches of the armed forces are employing physical education instructors if they can be found. Many have been taken from the schools.

In view of this demand, adequate provision should be made in universities in Canada for the education of teachers in both health education and physical education.

Courses might be conducted in those universities in which the subjects of anatomy, physiology and psychology are taught to medical students and in which the subjects of health education and physical education have members of the staff qualified to teach these subjects.”

I have prepared another graph just to show the relationship between health education and medical education which may be of interest. In doing so, I have had to design a new word, “hygeialogy”, because, as Dr. Ryle whom I quoted in “The Science of Health”, pointed out, there is no science of health corresponding to pathology, the science of disease, or of what we call pathology, which we have in medicine. Our course consists of anatomy, histology, chemistry, physiology and psychology and has what we call the pre-clinical part of the medical course.

And then we go on to the study of the science of disease, to the study of pathological anatomy, the disease changes that can be observed in structures with the naked eye—pathological histology, pathological chemistry, pathological physiology and pathological psychology. Then we go on to the study of the art and practice of medicine, taking the history of a person and making a physical examination, the object of which is to make a diagnosis of the disease; following this the curing of disease by medical, surgical or other methods is taught. There is also in the medicinal course, the teaching of the prevention of disease and of public health.

Now, when we come to apply this principle to the science of health which I have called hygeialogy, which is taken from the word "hygeia" and "logy". Unfortunately, we cannot use the word hygiene because it has obtained by practice a connotation of certain things relating to sanitation. Now, consider hygeialogy as the name with reference to this broad concept of the art and science of health. In the health course at the University of Toronto what we are doing in this course is teaching anatomy in relation to health—hygeiological anatomy—and we are taking chemistry in relation to health and histology in relation to health i.e. microscopic changes of tissue; and then there are hygeiological physiology and hygeiological psychology. In other words, the student of this course would get the same consideration as a medical student, with this difference that in this course the student is applying the facts and theories to the health of the individual. Health is dependent upon the quality of the structures of the individual, when you come to examine him, upon the efficiency with which he performs his functions and upon the adjustment that he makes to the environment in which he is living. If we follow this concept throughout we have the art and science of the practice of health just as we have the art and science of the practice of disease.

We take the history of the well person, the physical examination of the well person, the object of which is the assessment of health i.e. to place a man in A, B, C, D, or E category. You assess his degree of health as an individual. If he is in a high category, an A category, you have to see that he maintains his health, and many people need to have education in regard to that. As I say, we are just beginning to realize that something can be done to make people better.

In reply to a statement by Mr. Wood, I would like to point out that the agricultural scientists have taught the farmer how to adjust his soil, select his seed, in order that the crop will have good health and the land will produce fine crops; in other words, the application of science is made to the growing of fine crops and fine fruits and fine cattle and fine chickens. The farmer knows enough to give his chickens exercise because he gives them straw to scratch in, and we are just beginning to realize that this same treatment should be applied to the human organism in order to raise the standard of health. That is the purpose of this course, to give the students the knowledge so that they can go out and spread it, and I am looking forward to this occurring in the distant future rather than in the immediate present; but the sooner we can get going along this line the sooner we shall arrive at the desired destination; but I know it is very difficult to get an old dog to change his tricks. One cannot hope to get the present generation of men over 30 years of age to take much part in physical activities or physical development; indeed it would be wrong to try to do so if they are not capable of doing it, and if they have not done so, they are likely to suffer from doing it too vigorously. On the other hand, I would like to point out that a man is never too old to play games. I have an old friend of 90 years who plays eighteen holes of golf every other day during the week. I curl with three or four men between the ages of 80 and 90; our oldest curler is 91 years of age and he still curls. You need never be too

old to play games and have a recreation and in that way maintain your health at its proper level. If a person is not in A category you have to institute steps to raise the standard of his health to a higher grade and for that purpose we need trained people and educated people to carry out the particular steps.

Mr. AUTHIER: In connection with physical exercise, is it not a fact that certain disabilities are found in adults due to unsupervised physical training?

The WITNESS: Very likely; that has happened in the past.

Mr. AUTHIER: And do you not think that many cases of heart condition are due to overphysical exercising without proper supervision?

The WITNESS: I rather think the other way; I think the medical profession have gone too far in their fear of exercise and its effect on the heart in the case of older people.

Mr. AUTHIER: Is it not possible to overdo it?

The WITNESS: Yes, if a person has not been taking exercise; but take these old men of eighty who are still taking exercise, they are not having the slightest trouble with their hearts because they have been taking exercise all their lives. On the other hand, take the man of fifty who begins worrying about his heart and will not walk upstairs because he is afraid he will put a strain on his heart, he is doing the best thing he can to weaken his heart. The heart needs a certain amount of stress and strain to keep up its muscular quality, and if you keep on giving it exercise in a reasonable degree you will be helping to keep a man living longer and stronger.

Mr. AUTHIER: But the heart can be overstrained?

The WITNESS: Not if you build it up. Even overstraining in youth rarely shows in older years. The trouble is that people do not play games for ten years and then go out and play a game of tennis and drop.

Mr. HOWDEN: Is it not a fact that many athletes die young?

The WITNESS: No statistics would show that. Physical activity is based on a fundamental principle in relationship to all living things. Movement is one of the fundamental biological factors for all living things right from the simplest single cell organism, the ameba, inside which the whole protoplasm is in a constant state of agitation and movement when seen in a moving picture. The organism can move about in its medium, and if you look at living cells under the microscope you will see that they are constantly in a state of movement. Movement is necessary to keep the quality of the structure going. There are functions to be performed and the performance of those functions is necessary to maintain the quality of the structure.

Mr. FULFORD: If a serious heart condition sets in violent exercise is not going to improve that condition.

The WITNESS: No. I am not advocating exercise for a person with a diseased heart. The main point about all this, and this whole physical fitness aspect, is the fact that any individual who wants to take active exercise—and that is why I believe that health should be connected with this matter—should have a physical examination before he undertakes any exercise. We are carrying out a physical examination in most of the universities and most of the schools to-day. There should be a physical examination before these people are permitted to take exercises so as to make sure that there is no heart disability. But do not misunderstand me, I am not suggesting that a man with heart disease should take exercise.

With reference to the teacher aspect I have a few words that were published by Sir George Newman with regard to the building of the nation's health in Great Britain. He says:—

The Board (of education in Britain) introduced physical training into the education curriculum of all elementary schools, and of the secondary

schools under the local authorities in 1911. In order to equip the teachers to teach this new subject it was similarly included in all the training colleges for teachers.

And he goes on to describe the keep-fit classes.

I happened to be reading a book on the practice of medicine in Russia by the professor on the history of medicine at John Hopkins university Dr. H. E. Sigorist in which he has touched on physical culture, as they call it in Russia, and I would like to read it to you to show you the development that has taken place during the last twenty years:—

Council of physical culture established in 1923. There are representatives from the commissariats of education, health and defence and from trade unions and party groups. The functions of this group were to co-ordinate all efforts designed to develop physical culture, to supervise and guide the actual work, to train teachers, to promote research. Tsarist Russia spent 80,000 rubles in 1916 on physical culture; in 1936 the state budget of the U.S.S.R. spent 76,800,000 rubles, and in 1937 the state budget of U.S.S.R. spent 96,752,000 rubles. These do not include local and individual contributions.

That gives you some conception of the development.

It has been estimated that there are now (1937) at least 25,000,000 people who are taking some part in the physical culture movement.

The demand for teachers of physical culture is tremendous. Training schools of university standard were established early in Moscow, Leningrad, Kharkov, and Baku. They prepare about 4,000 students annually in four-year courses. There are also twenty technicians who train about 4,000 teachers of medium qualification every year, and twenty-three physical culture departments in normal schools with some 3,000 students. Special courses of several months' duration are held in the villages for the training of 10,000 physical culture instructors in rural districts. All physical culture schools have medical departments in which physicians receive special preparation for serving as sport physicians.

That gives you some conception of the development that has taken place there. Similar development has taken place in Great Britain and other parts of the world. Of course, the physical education people are aware of the distance that they have gone in Norway, Sweden, Finland, Czechoslovakia, Germany, and so on, and they are all fundamentally right as regards the principle of physical activity in order to raise the standard of health.

With reference to the Act itself, I should like to have you consider, instead of calling it the "physical fitness" Act you enlarge its scope and call it "health, physical fitness and recreation act." I should like you to include "recreation" in there. I shall explain that. I am copying the British Act of 1937 and it was the "Physical Fitness and Recreation Act." There it an extraordinary attitude of the people toward physical fitness and physical training. I see that in the university all the time. If a student can dodge the training and take the minimum he will do so. The only way that attitude can be changed is for the authorities to substitute a sport or recreation that they want to play and so get their credits for that. If the point of view could be enlarged to include health and recreation you would then have very much greater support and enthusiasm from the people that you have to encourage in relationship to this matter.

I should like to draw attention to a publication of the Canada and Newfoundland Education Association which came out in March of this year. In the chapter on health in this publication there is proposed: "An adequate health program will thus comprise the following and require the stated sums

annually." This applies to the schools not to the development in industry or commerce or in the older people—

(1) An immediate investigation of conditions, \$200,000.

(2) Special grants to stimulate improved health instruction, \$1,000,000.

They go on to give the amounts in the local schools in the way of medical examination, and there are two amounts that they suggest as the result of their study; I would like you to consider the possibility of making the amount of the grant considerably greater than it is and make the program a broader one instead of one that is limited to the physical fitness aspect only of the matter.

If you work the Act out on this broader conception I think it will really go across as far as the people are concerned. I think it will play a marvellous part in the future of Canada. Everything is set for a movement of this kind, if we can get it going—and it has started. Our school in Toronto and the McGill school and Saskatchewan are the only schools in Canada at present. The facilities are altogether too limited for training teachers. Every university or medical school should have a health course to train teachers with respect to health education. I suggest that clause (a) instead of reading as it does, "to promote the physical fitness of the people" should read, "to promote the achievement of positive health and physical fitness of the people of Canada." You should recognize the assessment of positive health as a possible procedure. The medical profession in Great Britain have recognized the problem. There are a lot of people who do not understand the assessment of positive health. I have tried to show you that there is something that can be recognized as positive health, and that we can do something about.

The second point is: "To investigate the adequacy of the existing facilities and trained personnel to institute a proposed health, physical fitness and recreation program,"—and that investigation should include the primary and secondary schools, the normal schools and the colleges of education. Strangely physical fitness and physical education are not taught in the normal schools in Ontario; I do not know whether they are taught in the other provinces. Physical education jumps from the kindergarten to the high school to the university. It misses the public schools as far as qualified leaders are concerned. I think teachers should be trained for that work in universities, colleges and other educational establishments, and that it should go on too "in voluntary community organizations and associations; in voluntary, commercial, industrial, labour or business clubs and associations; in voluntary camping, swimming and aquatic associations;

- (c) to assist in the extension of health education, physical education and recreation in the above defined group;
- (d) to encourage, develop and correlate all activities relating to health, physical fitness and recreation in urban and rural organizations in community health centres and playground activities, in beach, swimming pools and aquatic pursuits;
- (e) to endorse and actively support all activities organized and designed for the improvement of the health of the people..."

There is a publication in Great Britain describing their bill. They show the number of organizations, the voluntary organizations that are concerned. Here are four groups of different associations and lists of the voluntary and working organizations that were in operation when this bill was introduced. Here we have many of the movements going; we have to co-operate and help them to develop more rapidly.

- (e) to endorse and actively support all activities organized and designed for the improvement of the health of the people and for the develop-

ment of health education, physical education and recreation and to provide facilities therefore;

- (f) the inclusion of this clause is not considered advisable because the amelioration of physical defects amenable to improvement through physical exercise comes under the jurisdiction of the medical profession and the physiotherapist.

I think that will immediately give rise to controversy between the medical profession and the physiotherapists.

There were difficulties with respect to remedial gymnastics, in introducing our course in the universities. We are not allowed to teach remedial gymnastics to our students. That is the province of the physiotherapist. I think that last part should be left out.

Training of Teachers and Leaders in a National College of Physical Training.

I do not agree with this development in Great Britain. Of course, they are differently organized from what we are here as regards the establishment of a national college. We have educational institutions here with facilities to do investigation and immediately begin such a course as they began in Toronto. They can begin operating in those other universities.

As education in Canada comes under the purview of the provinces, it is proposed that in each province a school of physical and health education should be established either by the universities conducting a medical course or by other universities if no medical school is available. Such a school could be staffed by representatives from the faculties of arts and medicine (or if such is not available, the provincial department of health) the health service of the university, the department of physical education, physical training or/and the athletic department of the university and the faculty or college of education.

Educational opportunities should be made available for both men and women to be trained in the field of health education, physical education and recreation; and I should like to suggest that in the bill itself and in the incorporation of the council consideration be given to including representation from women as well as men because, as a matter of fact, the women have developed physical education and have been more active in it than have the men. There are many outstanding women teachers in this field who are keenly interested and well trained, and they could be very suitable representatives of this group on the National Council. I thank you very much.

SUMMARY

The purpose of my presentation to the Committee has been—

1. To show that health is a positive condition of a person and not merely freedom from disease.

2. To urge that plans be made for raising the standard of positive health and physical fitness of as great a proportion of the population as possible by 1953 by the institution of a program of physical activity, nutrition and mental hygiene.

3. To propose that the scope of the Bill be enlarged from that of "Physical Fitness" to "Health, Physical Fitness and Recreation".

4. To propose that "physical education" be replaced by "health education, physical education and recreation".

5. To propose that the suggested program include "normal schools and colleges of education", "rural and urban community centres," "industrial and commercial sports, athletic and recreational organizations".

6. To propose that paragraph (d) should read "to train teachers, lecturers, leaders and instructors in normal schools, colleges of education and universities in the principles and practices of health education, physical education and recreation".

7. To propose that paragraph (e) should read, "to organize physical activities designed to promote health and physical fitness and to provide facilities therefor".

8. To propose that paragraph (f) be deleted from the Draft Bill in view of the fact that the treatment of physical defects by physical exercises is the responsibility of the qualified Physiotherapist under the direction of a regular medical practitioner.

9. To propose that "the amount of such financial assistance in any year shall not exceed a sum which bears the same proportion to the sum of one million two hundred thousand dollars", etc.

The DEPUTY CHAIRMAN: Thank you, Dr. Ryerson. I understand the next speaker is Dr. A. S. Lamb, Director, Department of Physical Education and Director, School of Physical Education, McGill University. Dr. Lamb.

Dr. A. S. LAMB, Director, Department of Physical Education and Director, School of Physical Education, McGill University, called.

The WITNESS: Mr. Chairman, Mr. Minister, ladies and gentlemen, I deem it a privilege to be invited to express opinions about the proposed physical fitness bill. I think Dr. Heagerty in his suggestions was quite wise in suggesting that perhaps it might be well to prepare a brief which might be left for the consideration of the members of the committee. I have copies of this for the members of the committee, but probably after I get through you may not want to look at them at all.

To those who are responsible for the preparation of the proposed physical fitness bill, I would like to extend my heartiest congratulations. There are few virtues in war, and I am disposed to think that if there had been no such international turmoil, we might have continued with an all too complacent attitude toward the fitness and vigour of our people.

The greatest asset of any nation is the health of its citizens, and there is no more urgent problem facing this country than its future man-power. No matter how much we spend, nor how intensively we apply ourselves to the development, promotion and protection of our natural resources, it will be of no avail if we fail to care for and develop our human resources. If our man-power fails, then all else fails. We should be greatly heartened over the fact that such serious consideration is being given to the physical fitness of our present and future citizens, whether it be for war or the joys of peaceful living.

Future Man-Power

Sir George Newman said, "No nation is great which neglects its children" and there is ample evidence to show that heretofore we have not been as careful or attentive as we should have been to these obligations.

Whilst the wisdom of concentrated effort upon the conservation and mobilization of our natural resources is obvious, it is also obvious that we must ever keep in mind, that behind all these problems is the fundamental question of the man-power of our country. If it is inefficient, then production is minimized. If it is lacking in vigour, in strength, in endurance, then offence and defence are likewise affected. If the source of supply is lacking in vitality, is weak, defective and organically unsound, in other words, if the boys and girls of this country are physically unfit, what hope is there for the man-power of to-morrow?

It seems unnecessary to dwell upon the appalling disclosures of our human stocktaking—not only the percentage of those unfit to serve when presenting themselves for medical examination, but the 100,249 who were in the armed services but who, for various reasons, were discharged up to December 1942 (1).

The correction of remediable defects in their incipient stages, a reserve of strength and vigour, a better ability to meet the stresses and strains of service, all of which are attainable through an adequate programme of physical education, would have meant a significant improvement, it would not have prevented, of course, but it would have meant a significant improvement in these disabling conditions.

Dr. Heagerty's memorandum contains some information concerning national fitness movements in other countries, best illustrated in the totalitarian states, where the children are the servants of dictator control. We in our democracies have failed to realize the necessity of more careful guidance. Our problem is not only how we might stem the wastage of several thousands per month from the armed services—of putting men where they rightly belong, where they will be more contented and more useful—but it is part of a more comprehensive problem, one which should call forth all our efforts to safeguard the health and fitness of the generations to come.

Great Britain

May I draw your attention to the situation in Great Britain and the concern which was shown in the years immediately preceding the war.

In 1935, the British Medical Association appointed a special physical education committee to examine the then existing position of physical education from the point of view of the improvement of national health and physique. "The committee was expressly constituted to obtain, not only medical opinion, but also professional and technical information concerning this important and many-sided subject" (2). As an aid to its exploration of the problem, and in addition to oral evidence and written memoranda, several hundred questionnaires were issued to private, public and secondary schools, colleges, university training departments, industrial firms, voluntary organizations and foreign countries.

Brief extracts from the report are as follows:—

The aim of physical education is to obtain and maintain the best possible development and functioning of the body, and thereby to aid the development of mental capacity and of character. The mind and the body are so essentially one that the divorce between them in what is commonly called education, appears as unscientific as it is pronounced. . . . An educated body is a balanced body, just as an educated mind in the true sense is a balanced mind. Balance of body, mind and soul should go together and reinforce each other; and perfection of balance, physical, mental and spiritual, can be the only true and scientific aim of education. . . . It is possible to develop great strength without necessarily attaining perfect balance. . . . The problem of physical education is to bring home to the individual the knowledge that the body, like the mind, can be directed by the will, and to inculcate pride in the proper control of both.

A critical analysis of the situation in various walks of life is followed by specific recommendations toward increasing the standards of physical proficiency—that this be done on a national scale, planned, administered and carried out by some central authority—that the success of any such scheme is dependent upon a sufficiency of suitably qualified teachers and an intimate relation between physical education and the science and art of medicine.

It is gratifying to observe that the proposed bill indicates much similarity to the findings of the British committee and somewhat parallels established movements in other parts of the empire. However, like England, we are a little late in locking the stable door.

Prehabilitation

Rehabilitation and reconstruction are important aspects of any plan for social security, but is it not even more important that most aggressive steps

be taken toward prehabilitation, either to win this war or to enable the forthcoming generation to live more wholesomely and happily? Surely this war is being fought for them and their future. Investments in our victory bonds are essential, but investments in our future citizens are even more essential and will pay far greater dividends.

May I refer to the report of the survey committee of the Canada and Newfoundland Education Association, to which Dr. Ryerson referred, recently appointed at the request of the Advisory Committee on Reconstruction, to ascertain the educational needs of the dominion (3). The committee was asked to list in order of immediacy the needs of education in Canada. That committee, as you know, was composed of outstanding educational authorities across the country, and of the fifteen items listed, "Health examination and follow-up treatment for all children" was listed as number one. The report stresses the fact that "The first aim of schools is to develop young Canadians sound in mind and body"—that healthy children are public assets and that sickly ones are liabilities. Most illuminating recommendations concerning health will be found on page 18 of this report.

Investigations among school children have disclosed staggering percentages of unfitness, such as:—

- (a) Ninety per cent of the children in elementary schools without dental care, have dental defects which, if neglected, will cause ill-health and retard education.

This is not my statement, it is a quoted statement from that report.

- (b) In a recent study of 70,000 school children, only 45 per cent were found to be in a normal state of health.

That is not my guess at all. This last study was in one province. The first one, the 90 per cent, is the statement quoted from the Canada and Newfoundland Education Association report. Every time I make a quotation or a statement I have a reference number showing the source of authority, and you will find them at the back of this report. These are rather staggering figures.

There are three and a third millions in Canada 14 years of age and under, (28.5 per cent). There are nearly four and a half millions under 20 years of age, 38 per cent of the total population (4).

Proper health supervision for every school is a crying need and, in our search for causes and origins, it is obvious that our attention should be focused on the young, so that correction of many deficiencies and progressive ailments could be effected.

Correction of physical defects, the building of strength, vigour, agility and endurance, cannot be done overnight, nor can real progress be made unless there is a broad vision of the child as a living, dynamic machine with an intimate and inseparable relationship between its physical, mental, moral and social components. Particular stress was placed on this matter at the annual convention of the Canadian Physical Education Association held in Vancouver in June 1939. The slogan of this pre-war gathering was "A national fitness program for Canada".

Delinquency—Charitable and Benevolent Institutions

As you know, there is an amazing increase in juvenile delinquency. The convictions (under 16 years) for major and minor offences, increased from 7,035 in 1938 to 8,431 in 1940—an increase of nearly 20 per cent. The convictions of persons for major offences in the age group 16-20 has increased 46 per cent in the period 1931-1940 (4). England records a 41 per cent increase in the age group under 14 years for the period twelve months pre-war to after twelve months

of war. And you must have read of the rather staggering increase in various parts of the country within this last year.

There were, in 1940 over 54,000 people in our charitable and benevolent institutions. Of these 38,000 or 70 per cent, were under 20 years of age (4).

A recent publication, showing causes, and the contribution that recreation can make toward minimizing juvenile delinquency has just been issued by the National Recreation Association of the U.S.A. (5). The economic aspect of these problems is not overlooked.

Industry—Morale—Health

Apart from conditions of disease and obvious disability, there is another and less easily discernible state of the nation's health which we might, for want of a better term, call morale.

A recent publication by the American Psychiatric Association (6) dealing with certain aspects of civilian morale, contains a number of significant observations. Upon morale depends, in a great measure, the outcome of the war. Where morale is high, individuals and groups keep working and fighting in spite of the most adverse circumstances. Where, on the other hand, morale is low, efforts slacken, inefficiency grows and courage is lost. Every executive in defence services and industry, just as much as those in authority on the firing line, must recognize the problems of morale, learn how it can be built and strengthened, and understand the relation it bears to the problem of absenteeism.

Good mental health is even more important than good physical health as far as the maintenance of morale is concerned. Browning said, "Thy body at its best, how far can that project thy soul on life's lone way". The chronically anxious-minded person, the constant complainer and the suspicious anti-social individual is a very bad risk. Fatigue, which is a major problem, means a reduction in output, an increase in sickness and accidents, errors in judgment, the dulling of initiative and the poor physical and mental health which naturally follows.

Conditions of work, noise, lighting, temperature, humidity, optimum working hours, nutrition, adequate rest and exercise, monotony, nervous tension, fear, a sense of isolation, etc., are significant factors, and fuller recognition should be given to the potential values in correcting these difficulties, in promoting an optimistic cheery outlook and in increasing physical and mental health. Poor physical and mental health is the unrecognized saboteur on the production line, just as it is in other walks of life.

A conference called by the Department of Labour, met in Ottawa on April 9, 1943, to discuss the significance of recreation and physical fitness in industry. I am taking the liberty of attaching to this memorandum, appendix I, which gives a summary of the findings of the conference. Regional and local recreation councils have been set up in certain areas in an effort to meet the need for facilities and personnel. Preceding this conference, and in an attempt to cope with the situation in the Montreal area, a short term recreation training course for leaders of industrial recreation was conducted at McGill University from October to December 1942. (7).

That is, we took people from industries and put them through a brief course of training in order that they might go back to assist in the recreational activities of the industries.

Attention is also directed to the "block plan" instituted by the National War Services Department. I do not know much about it, but I made some reference to it in the brief.

I refer to these two departmental enterprises in order to suggest that whenever and wherever questions of national physical, mental and emotional welfare are being considered, the most desirable results are to be expected through co-operative endeavour.

Training of Teachers

We cannot legislate our people into fitness and good health. We may furnish the facilities and equipment but these will be of no avail without a sympathetic co-operative attitude on the part of our citizens. Such an attitude can only be attained by competent and skilful leadership. I am sure you will agree that it would be extremely difficult to force people to eat the right kinds of food, or do the right kinds of exercise at the right time. We cannot impose fitness any more than we can impose honesty, or loyalty, or morale, or any other attribute of character. The desire to do these things must grow from within the individual, as a result of what he experiences and those things that we do for him. We can furnish the opportunities, we can set the stage, so to speak, and hope that the responses will lead to sound convictions and desirable habits of living. These things cannot be achieved without good teaching and skilled leadership.

McGill University has been training teachers of physical education for over thirty years; other courses are given at the University of Toronto and Saskatchewan. The man-power problem and the opportunities for more gainful employment have led to a great dearth of teachers, and the rapidly diminishing number of students in training would indicate an even more acute problem for the future. This should be remedied at the earliest possible moment.

Physical Fitness and Functional Capacity

A sound organic system, i.e., absence of any abnormal findings upon examination, does not mean that a man is either physically or functionally efficient. This fact has been brought home most forcibly in recent years. A man must have faith in what he is living or fighting for, and in those who are leading him. Total fitness involves mental and emotional fitness, as well as physical fitness. The mental attitude must lead to well-disciplined co-operative endeavours and the emotional reactions must be harnessed before a person can become a sound social being. Convictions as to the justice of the cause will foster a courage and determination to succeed and those most desirable and cherished traditions of our Empire, morale and esprit de corps will be maintained. A high percentage of the discharges from the armed services, to which reference has already been made, was for upsets which were wholly psychosomatic. It was a mind-body relationship. If it is wise to increase the value of our man-power for war, and in this all will surely agree, then is it not doubly important that we should be no less interested in these things for better and more wholesome living in a peaceful democratic society. We must be strong for the emergencies of war, but fit for the peace of to-morrow.

Trends—Physical Education

Significant trends have marked the progress of physical education, and one of the most important has been the realization that, although a person may be sound organically, he still has much to do before he can become physically fit. Strength, endurance, agility and co-ordination are worthy objectives for any walk of life, but they are not easily acquired—they must be worked for.

There are numerous methods of testing organic and muscular fitness, but perhaps the ones which show the greatest promise are the Brouha tests (8) from the Harvard fatigue laboratory which have just been announced. We now seem to have tests which may enable us, not only to measure the fitness of the mechanical aspects of the machine, but also how the individual will react to other members of society, and how he will stand the stresses and strains of trying experiences.

Mr. Minister, if we had tests like that, it would help greatly in the political field, I would judge. Most programs of physical education are to-day incorporating toughening and conditioning exercises to fit people to meet the

emergencies of present day living, exercises of the commando type rather than the other types of activities previously taught.

It is possible and desirable in any national plan which might be evolved, to work out a satisfactory series of efficiency tests for boys and girls of all ages, so that they can clearly see how they compare with an approved standard. The incentive in any such plan would tend to stimulate interest and a desire for achievement which could not be secured in any other way.

The Proceedings of the National War Fitness Conference (9) held in Cincinnati, Ohio, April, 1943, and the "Physical Fitness through Physical Education" (10) publications contain much valuable information about these matters.

References are appended, and copies are here so that if, after you adjourn, any one would like to glance at them, he can. I cannot leave copies of all these publications.

Observations

1. Much authentic information could be submitted to show that the health and vigour of our young people is far from satisfactory and that the present methods of meeting the problem are totally inadequate.
2. There is irrefutable scientific evidence to prove that a properly organized program of physical education can make an important contribution toward physical, mental and emotional fitness.
3. The Proposed Bill marks a mile-stone in progress toward a greater degree of fitness for the people of Canada.
4. The appointment of professional, technical and other officers (para. 3, (10), page 2), and the training of teachers (para. 4, (d), page 2) of the Proposed Bill, are essential for the success of the plan.

These, as you know, are provided for in the bill.

5. Close co-operation should be established with other Departments of the Government, Federal and Provincial; also health, medical, educational, professional, social and welfare organizations.

(Mr. J. G. Lang, President of the Canadian Physical Education Association, has authorized me to submit as Appendix II, a Special Bulletin which sets forth the attitude of the Association toward the proposed Bill).

6. The facilities and personnel of all related organizations should be utilized to the fullest extent.
7. Standards and procedures should be drawn up covering medical examinations, syllabi, programs and proficiency ratings.

And, most important:

8. Policies and objectives should be carefully defined. Co-operation with voluntarily administered organizations in the control of competitive athletics should be established. Assistance should be given and conflict avoided.

Let us not jump before we know where we are going to land.

9. A greater public consciousness of the importance of all-round fitness should be stimulated through demonstrations, discussions, the press, the radio and moving pictures.

Conclusions

The complexity of the many problems with which you are dealing and the numerous panaceas you must have already received, are fully appreciated. When one considers the future cost of sickness, it is apparent that any steps which are taken to prevent disease and promote health, are economically

sound, but what is vastly more important, is that our people will enjoy fuller and happier lives. We should be much more concerned with the development of sound organic and functional fitness of the masses, than with the development of highly specialized athletic abilities by the few.

The opinions of experts in the fields of medicine, education and physical education have been submitted, and one can expect almost complete unanimity of support for this aspect of social betterment. It should proceed at once as a basis for other developments in social security.

There is no more urgent need, there is no better investment, and there can be no richer returns. I wish the proposed Physical Fitness Bill and you, Gentlemen, every success.

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- (5) Teen Trouble (What Recreation Can Do About It). National Recreation Association, 315 4th Avenue, New York. (10c.), April, 1943.
- (6) Psychiatric Aspects of Civilian Morale. American Psychiatric Association, 122 E. 22nd St., New York, N.Y., 1942.
- (7) Industrial Recreational Training Course Bulletin. Department of Physical Education, McGill University, Montreal. December, 1942.
- (8) Selection of Officer Candidates—Studies in the Relation of Personality to Field of Work. Harvard University Press, Cambridge, Mass., 1943.
- (9) Proceedings of National War Fitness Conference. American Association for Health, Physical Education and Recreation, 1201-16th St. N.W., Washington, D.C., April, 1943.
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The DEPUTY CHAIRMAN: Thank you, Dr. Lamb. Are there any questions? If not, the next speaker is Mr. A. A. BurrIDGE, Physical Director, McMaster University at Hamilton, Ontario.

Mr. A. A. BURRIDGE, called.

The WITNESS: Mr. Chairman, Mr. Minister and members of the committee, at about this time I think your minds are on nutrition, and I shall try to be as brief as possible. My interest in such a thing as a national physical fitness bill, of course, goes back some little time, to when our organizations throughout the province of Ontario and throughout Canada were very desirous and emphatic in their feeling that there should be such a bill established. My connection, or at least my knowledge of what was going on down here in Ottawa, came about a little over a year and a half ago when I was attending a meeting of the Inter-provincial Rugby Football Union, and discovered that they were all of a mind that they should disband all sports during the war. They did not want to, but they feared criticism. It had come to the point where the average man of our age was afraid to go out and play a game of golf. He was loathe to do it because he felt there might be some stigma attached to it. They felt that there should be some statement from the government which would allow us to take part in recreational activities for our own good, and delegates were appointed. I happened to be the spokesman. We interviewed Mr. Ralston. It was he who

was mentioned as the one that we should see. He properly turned us over to Mr. Mackenzie and there it was that I was pleased to find he had a wealth of material on his desk or on file on this very thing, and was looking forward to such a bill. I also had the privilege a little later on of conferring with Dr. Heagerty, when some of the clauses of this bill were being planned, and it looked like a very good thing, and something that at least I, and those of us of the student unions and other organizations felt should be told to the public. I asked at that time if some statement could be published that would show that the government had an interest in the well-being of the people, and Mr. Mackenzie was quite gracious about issuing a statement which the Canadian Press broadcast at that time. That was the one thing needed for some of us throughout the provinces to urge the organizations which had to do with physical activities, physical education and sport, to continue and which hindered them from disbanding or from curtailing their activities. Of course, such things as travel and equipment enter into it; but that is another angle altogether. Where it was possible for these organizations to carry on, we tried to induce them to do so. I speak with knowledge of over fifty organizations which are connected with physical education, athletics and kindred activities, who know that there is to be such a proposed bill and have been operating in the last year in the expectation that something would come through that would help them to carry on their activities. I do not mean something that would help them financially, but something which would help them morally, if you like—give them moral support. I have been able, during this past year, to attend the meetings of numerous such organizations and speak at the meetings. I have had conferences with their executives, and correspondence. So when I say "fifty organizations" I could really enlarge that; but many of these organizations have sent letters in to the Department of Health and I know that they have them on file at the present time.

This bill that has been planned, then, is not one that has been hastily planned. A great deal of thought has been given to it. The bill itself is not new in conception. The speakers before me have brought out the fact that Russia, the United States, South Africa, Australia and other countries too have very well organized plans at the present time; and there is no reason why we cannot go ahead with this and in time have just as hearty, just as full an organization and program as any of these other countries. We are following them, it is true, but the Mother Country followed them too; and we are hoping that Canada can do that as well as England.

After Pearl Harbour, the Americans, although they already had a "Hail America" program, which was a physical fitness program, immediately got busy; and overnight the college curricula of many of the colleges were changed immediately to place far more emphasis on physical fitness than had ever been placed on it before. During that month, at Detroit, there was a national conference of directors of physical education. I flew over to attend it, and I was very much interested to hear how intensely concerned they were about a physical fitness program, and how the curriculum of a college should be changed to insure our young being more physically fit, even if they had to reduce the academic load as a war measure. The city of Hamilton during the last year—just as Dr. Lamb and his associates in Montreal and Quebec have been doing—has become very much interested in the program and a council has been formed there. There has been made a survey of the entire city, of every organization—that would include industrial, management, city council, board of education and so on—with the idea of establishing a recreation program. I may say that it was due to a visit of Captain Eisenhower that they really got busy on it. Since then they are placing more and more emphasis on the physical fitness side of it, not forgetting the recreational as well. The Ontario government, I under-

stand, has also set aside a fairly decent sum of money to foster physical fitness among the youth.

I see that the time is going. I had a paper prepared here, but some of the material has been covered by the previous speakers, so I shall just go on and touch a few of the things that I thought were more important than some of the others.

Among the workers in industry, it has been found that the increased demands on the workers' endurance and nervous energies are taking their toll. Fighting and working to-day entail the use of all man's manifold abilities.

We realize that, physically, our people have been neglected. The present emergency has shown the need for a citizenry (not only those in uniform) that is physically fit to serve. Endurance, agility and skill are essential qualities of the soldier and worker alike. Unfortunately the surveys of Selective Service reveal some fundamental weaknesses in the people: defects, deficiencies, disorders and diseases, all of which curtail efficiency and constitute handicaps. Although to win this war we must have men with strong bodies and plenty of stamina, 25 per cent to 50 per cent of the men at the enlistment depots are physically handicapped. Among the accepted men, in the United States, one research showed that the average man in category "A" was unable to chin himself once, jump a fence waist high, or run a half mile at his own pace. A rejection rate of 50 per cent means a curtailment of manpower of 50 per cent. It is obvious that if defects are so prevalent among young men of military age they must exist in a larger percentage among the rest of the people of the nation.

With the dominion trying to maintain a reasonable uniformity between the provinces in a physical fitness program, many of the defects discovered by Selective Service would be easily remedied. Physical education activities can make their contribution to the positive side of health and mental hygiene by creating a background for wholesome development. Building up a nervous system which has to carry the burden of modern civilization means building power for action out of the latent resources of the body. There is ample experimental evidence to prove that men and women, boys and girls who engage in muscular exercise moderately and consistently really do enjoy better health and develop a greater reserve. Some people may feel that we must learn to do without recreation and sports and the art of living for the duration, but we realize that the fundamentals of morale are buried in our art of living.

What we do with our recreation tells what we really are better than what we do at our work, it has been said. The well-being of the community depends to some extent on how we vote at elections, but it depends far more on what we do with ourselves in the interval between elections. The greatest lack or fault in our national system of education lies in the field of physical education. It is our duty to see that the centre of gravity of the educational system is shifted so as to cover physical preparedness, and interest and skill in physical activity. I was interested to read a report of the efforts of the State of Indiana in handling a program for physical fitness as it applied to schools and colleges. The stress is to be laid on obtaining more time for intramurals, more equipment, more and better administration, more effective teaching, and a program that will have every one in some activity. They emphasize Keep Fit Clubs. They have established a curriculum committee to devise a long-term curriculum with increased emphasis on physical fitness.

If the present bill is approved, Canada can plan a similar forward movement to that of other countries. Up until the time the bill began to be talked of, we in Canada have been victims of a form of hysteria. Prominent men said, "Winning the war is our first consideration. Sports are all right so long as they do not interfere with this effort." Another slogan says, "Nothing matters now but victory." But those of us closely connected with physical education

have been convinced from the beginning that sustained effort cannot be maintained without a background of health and fitness through recreation. It is just as reasonable to try to step up the tempo and increase output by cutting out sleep as to make a similar demand on the emotions, and provide no relief from tension and fatigue. The re-creation of a hardy race of people similar to the pioneers of Canada, barring manual labour, can be realized only through the introduction of a program of sports that extends far beyond anything we have hitherto contemplated. It would include regular participation by almost every member of the population, with special emphasis on youth and rugged outdoor sports.

Your proposed bill paves the way for such a course which will improve the fitness of our youth. This must be done for the average young man as well as the student, for what is good for the student is good for the non-school man. There are facilities in hundreds of schools and colleges for gymnasium and swimming pool activities. These facilities should and could be made available to Mr. John Public. There are thousands of well-trained directors of such work, and more could be made available by Selective Service. The National Council should urge all peacetime unions in sports not to curtail their schedules unless forced to do so by lack of travel facilities and equipment. Incidentally, the United States has appointed a co-ordinator to study ways and means of permitting limited travel and more equipment for the clubs. Although these clubs would have to operate with team members of lesser calibre, they should be encouraged to see that the qualities gained by the players in combative sports are exactly what a soldier needs. Those of you who have seen and have been connected with football know that that is true. The footballer learns to take orders, to size up quickly the opponent's intent, to get to the danger point, with coolness under stress, with ingrained habits and trained muscles that have been acquired during the training season. Those are things that are essential in the soldier and in the business man.

Given a revision of attitude toward the place of sport in wartime, given the active co-operation of every organization designed to carry on athletics, given not only government blessing but government sponsorship, there is every reason to expect a vast improvement in our national fitness. This would permit shortening of the training time of our soldiers, thus enabling the country to place our armed forces where they are needed "fit and ready." The soldiers of production could carry the load with less fatigue and absenteeism, and the younger generation would be ready to take over that job which they will inherit, that of "putting the world together again."

Thank you very much.

The DEPUTY CHAIRMAN: Are there any questions to be asked? If not, I would call upon Captain Eisenhardt.

CAPTAIN IAN EISENHARDT, Department of National Defence, called.

The WITNESS: Mr. Chairman, Mr. Minister and members of the committee: I am afraid I have no brief to submit to this committee because I did not have enough time left between the time I was warned I was to come here this morning and now. My learned colleagues have given you a picture; and I think I will just describe to you, in a very brief way, the picture as I have seen it in Canada since I arrived here in 1929.

I came here under a scholarship from the University of Copenhagen. It was really won on a little thesis of how a young man could get along in the world. I emphasized there that if you knew the sports and games in whatever country you came to, that was your introduction right away to life with those people. In England I had played cricket with the clubs there; in France I had fenced and played tennis; in Germany I had taken part in football.

Right away you had an introduction to the homes, and from then on an introduction to living with the people. Arriving in Canada I was very fortunate in being given a position in the playgrounds. There in the east end of Vancouver I had a playground called McLean's playground, where there were thirty-six nationalities—Scandinavians, central Europeans, Canadians of the first generation, Japanese and Chinese. To keep all these boys and girls going was quite a job, especially because none of these boys and girls wanted to play together. They came to the little clubhouse and they wanted a ball. I gave one to the first group. The next group would come and they also would want a ball. I would say, "Why do you not go and play with the others?" They said, "Oh, no. We do not belong to that nationality. We are by ourselves and want to play by ourselves." At that little playground, through the work of my co-workers and through the inspiration of our superintendent of recreation, we really formed a league of nations. We got those boys and girls to play together, and consequently to live together. Around this playground were nothing but bootlegging joints, as they are called, and the children came from very bad homes. But they learned a very fine lesson at the playground in the east end of Vancouver.

In 1934 it was my very good fortune to meet Dr. Weir, Minister of Education out there, who was interested in a program for health. We discussed it, and we submitted plans to the cabinet and in 1934 was born this plan called the "Pro-rec" scheme—provincial recreational centres—which grew from 3,000 members in 1934 to about 30,000 to 35,000 members yearly in the years 1937, 1938 and 1939. This scheme plainly is an adaptation of the Czechoslovak scheme of, the Sokol, the Englishman's conception of sports and games and the Danish idea folk high schools. Having mixed those things together and brought in the Canadian picture, we had a very fine youth training program in British Columbia. At the time of the Purvis Commission there was a committee called the National Health Committee under that commission, and it was my privilege to attend the committee meetings. The fourth clause in the Dominion-Provincial Youth Training Program called for the physical rehabilitation of our young unemployed. Through that Dominion-Provincial Youth Training Program it was possible for every province in the Dominion of Canada to obtain assistance in regard to the physical rehabilitation of the young unemployed. The idea was adopted in B.C. We had it already, but we received the benefit of added monetary assistance. Then, in Alberta, Saskatchewan, and Quebec they had a small program, and more provinces were going to take it over, I am certain. But I would say that Canada, as a whole, took a benefit from that program. They could have, because there was money set aside for it.

Working with the young unemployed was very interesting. It was very sad, but it was a very interesting experiment. These young people seemed to think that they could not do anything for themselves if they had no money. They would come to our recreation centres. They would stand and watch others play and they had no desire to take part, generally, because they did not know how.

All these young unemployed were products of our own schools, but they did not know how to play the simplest national games of Canada. So we had to adopt a system of getting right down almost to the children's level, take these grown up people and teach them how to throw a ball, how to catch a ball, and show them what it meant to play together. By teaching these young people to play together we taught them to live together. That is really the great benefit that comes out of the recreational and physical training. The discipline of adhering to certain rules in the game so affects these young people that it becomes second nature. If through physical education and the spirit of democracy you can teach them citizenship in a live way, then they become an asset. In our Canadian clubs in B.C. we have this plan going all over the country, not only in

the cities but in the rural districts. When the war started I had a nice experience, that was, to work with our soldiers, and again here I must say the physical fitness was not up to the standard that it should be. I remember so well travelling in Europe where we saw pictures of Canada in the person of a red-coated six-foot mountie. We saw pictures of the lumberjacks, the trappers and the miners. All over Europe that is the picture they have of Canada. Hitler has not said anything derogatory about Canadians. He said the British are decadent and the Americans are decadent, but he has a picture of those husky Canadians. They are the only pictures he sees of Canadians. Now, we should not let him down. This bill that is before your committee is one of the greatest importance.

May I say I have known Dr. Lamb for a great many years. As a matter of fact I was given three names by my professor in Copenhagen. One name was Dr. Lamb, another name was Jack Wright, the tennis player, and the other was Mr. Molson. I met Dr. Lamb; Dr. Wright beat me in a tennis match, and Mr. Molson I could not escape anywhere.

Many of our young people cannot escape Mr. Molson nor, shall we say, commercial recreation, because in our communities in Canada we have hardly any other recreation. I generalize, Mr. Chairman. We have very little recreation, I say, outside the commercial recreation. We have certain municipalities, we have certain provinces, who are interested in our young people, but they are only scratching the surface. There is really nothing big. Even our work in British Columbia is only a quite small thing and just beginning. As a matter of fact they could become really big. The commercial recreation has provided all the entertainment, all the amusement and all the recreation for our young people. All they have to do is dig down in their pockets, take out some money, and they get all the recreation served that they like. Most of our young people cannot escape this recreation because in the communities where they are there is nothing else for them to do. The beer parlours, pool rooms and dance halls, all these things are fine, they may be all right, but if these are the only things for our youth it is not very good.

I have gone into villages and little cities in my own province where I have discussed this matter of recreation with the key people. We have had a meeting with certain individuals and the next day I would be approached by people who said, "Why did you have these people out to such a meeting?" I said, "They are the leading citizens of this district, they should be there." I was told they might be leading citizens, but they really are competitors of a committee on recreation to provide the sports and games. I was told that all these people own all the beer parlours and pool rooms and they were not interested. I was told they might give me the official nod and so on, but they are not really interested.

Now, the picture as I see it throughout Canada is one of making great and sincere efforts on behalf of many—especially among the proper people—in organizing sports and games and physical education; but there is no concerted effort. There is not a national picture, shall we say. I hate to bring this up because you might get the wrong impression. But I think it is significant that whatever country Hitler marched into the people he wanted to get first were the leaders in sports and games and the leaders in physical education. When he went into Norway he got hold of Birger Ruud, the great ski jumper. In France it was the bounding basque Jean Borotra, the great tennis player. When he got into Denmark he got hold of our greatest sportsman, Faech Hansen; in Finland it was Nurmi. So it was all over the place. He got hold of the athletes because through them he would get the young people.

Not long ago I met our greatest sportsman in Canada who has two undefeated world championships as an amateur, and who is an undefeated professional champion. He is six-foot tall; he appeals to you; he has a great person-

ality. He is a man who should be actively engaged in training youth. Who do you think he is working for? He is working for a liquor firm because they realized the personality that he has, the great salesmanship that he possesses.

We have lots of people like that in Canada, lots of people with talent who should be, to use a word, exploited. We should use people like that in a scheme such as we are about to undertake. I do not say this man is a perfect teacher, but he has an appeal for youth. His accomplishments appeal to them; the fact that he is one of our best Canadians appeals to them. He would be the real man to put in charge of whatever kind of sport that he excels in.

Now, I shall touch briefly on the schools. Our schools are not adequately qualified with gymnasias and playing fields and sport clubs. There is a great piece of work to be done. Our universities are taking the matter of physical fitness very seriously and I hope we shall have, as Dr. Ryerson said, more universities training teachers in physical education. Even then there is a great piece of work to be done within our little schools, with our rural schools and with our schools in our cities.

I believe that physical education should be really functional. We should be able to see our young people develop as they are given the privilege of participating in athletics and games.

I quite often am approached by people flat footed, flat chested and round shouldered, who tell me that they used to be good at such and such a thing. They say, "I used to do this and so on." As I see it these people, because of physical education, should be energetic, strong, and people with a great personality. What is the use of physical training if it is accorded to a few people who can only look back and get a kink in their necks just from looking back. I would say our private organizations and athletic unions and so on are doing a great piece of work, but they are not supported by the provinces or by the government in the way they should be.

Now, about the army; I do not wish to touch on that as I am speaking as an individual this morning, but I would say that when I had the experience of training soldiers—and after hours I took a great pleasure in going out and playing games with them—I found the same thing again that I found with the unemployed, that you had to teach them games. This thing I think has created a certain inferiority complex that people are always looking at other people play. Because of that they say they do not like these things; secondly, that they have no interest in it, and all because of a lack of knowledge or lack of opportunity in early age for taking part. There is certainly a great thing we should take up through this physical fitness plan. We can give more people the opportunities they should have. As I say, in the army they have a great chance. I do not know exactly what scheme they are using, but we have a wonderful opportunity for really educating our boys physically, mentally and spiritually.

To come to the plan before you, I have read the proposed bill through several times and I can only say it is long overdue and the sooner we get it going the better. I should like to see more money spent on it. When I look at our budget in British Columbia of around \$100,000 in one province alone, I realize that the amount set aside may not be adequate, but notwithstanding that I would say that whatever beginning we have a larger plan will sink into the imagination of our Canadian people and there will be so great a benefit from such a plan that there will possibly be, I am certain, a great public demand for this bill to be extended and more money to be spent. It is the greatest thing we can have in a country like Canada; it might unite our people and perhaps even interest our young athletes in travelling from province to province when time will permit it. You will find democracy can be taught through physical training by teaching people to live together. People can be taught to live together in this way. This is one of the most advanced things that can be given support to, and

I hope, sir, that it will pass and in years to come we will have instead of \$250,000, \$50,000,000 or \$60,000,000 for that work. Thank you.

Mr. ADAMSON: I should like to ask Dr. Lamb a question. I gave a broadcast on the 1st of January this year. I said some of the things much milder and with much less information than Dr. Lamb has. The broadcast was more or less on the same line. I was attacked immediately by the Minister of Health of the province of Ontario, for raising absolute falsehoods and for being a monger of rumours that were absolutely untrue. He gave that statement to the Lion's Club in North Toronto. He said that my statement was not true. I had to come down here and get figures similar to what Dr. Lamb gave and publish them in order to defend myself.

The question I want to ask is, what are you going to do to educate the people with regard to conditions as you have stated them, which still exist? What are you going to do to make the people realize that they are not in the best of all possible worlds? Then, there is another question I should like to ask. Quite recently in the city of Toronto, where we have a most desperate housing situation, we had the John Inglis Company send out 10,000 circulars asking their employees if they wanted improvement in their housing situation. Of these 10,000 circulars sent around only 10 were filled out. What are you going to do to educate the people that they are not in the best of all possible worlds?

Dr. LAMB: May I endeavour to answer that? I do not know the name of the gentleman who spoke. I saw the report in the press and I was going to write him because when I hear of a person launching out on a campaign of that kind and being attacked, particularly from those in authority, he always has my sympathy because I have suffered likewise. I do not know that there is anything you can do about a thing of that kind except to be careful that you quote the facts, not rumours. I got caught that way once. Somebody said something and I thought it sounded very smart and I repeated it and it had no basis in fact. From that day to this I have endeavoured always to quote something that I can go back to, either a national association like the Canadian Tuberculosis Association or the Canada Year Book. I hate to believe what is in it, but it is an official government publication, and the figures I have given you are from the Canada Year Book, 1942, and the Bureau of Vital Statistics and other authorities of that kind.

I think if you persist in your efforts then you have to take the knocks and be a martyr because it is worth it. Does that answer you? Then, there is one other aspect. You speak of the ignorance of people about these things. This is the kind of plan, as I see it, which will ultimately correct that. You cannot do it overnight, but you can go around to the schools and get at the young people and sow in their minds the proper seed, and then I think there will be some improvement. Much of our trouble in the past has been due to this: young people in some of the provinces have been able to get a teaching diploma even without matriculation. They take them in, for instance, up to about the tenth grade and then they go to normal school and they become teachers in nine months. These are the people who are sowing the seeds of ignorance among our children.

Dr. HEAGERTY: Mr. Chairman, I think Dr. Lamb has replied very thoroughly and succinctly to Mr. Adamson. We who are in the public health field become extremely annoyed when we read extreme, exaggerated and false statements regarding the incidence of disease in Canada and particularly when the criticism is aimed at the Department of Pensions and National Health, and that in view of the fact that we have no direct opportunity to deal with any of the deficiencies.

There are many false prophets in the community, many uplifters who do not take the time, as Dr. Lamb has pointed out, to obtain the facts, although those facts are available. They simply adopt everything and everybody in sight and so naturally we become annoyed. Therefore I can quite understand why the Minister of Health of Ontario should have become annoyed with Mr. Adamson if his statements were not based upon the statistical facts. That is about the situation. I think Dr. Lamb has covered it pretty well.

MR. ADAMSON: I want to correct that statement. My statements were also out of the Canada Year Book. At the time I was amazed to think that the Minister of Education had not a copy of the Canada Year Book.

MR. FULFORD: Dr. Lamb himself said that this physical change could not be accomplished overnight. Did not Germany prove that it could be done in a remarkably short time? I refer to their "Strength Through Joy Movement", which unfortunately the Nazis used to their own evil end, and which is a great misfortune to the world. Nevertheless from 1933 to 1939, the outbreak of the war, there was a tremendous change in the physical and mental outlook of the German race. I happened to be in Germany in 1931 and returned in 1937. In 1931 one did not have to be—what is that new word that Dr. Ryerson coined—the hygeialogist to see the difference in the physical appearance of the average person on the streets of Germany. Perhaps this cannot be done overnight; perhaps we cannot use the practices of reconstruction or the methods of compulsion used in Germany, but to me it does prove what can be done by proper physical education.

DR. LAMB: I heartily agree. If I created the impression that it was not worth while doing because it would take a long time that was not my intention. I also am familiar with some of the movements throughout Europe and was in Germany on a trip, too, and saw most of what they were doing in the construction of recreative facilities and fields and so on. Enormous fields were built for recreational purposes. I understand there were many of them and these, of course, are all airfields now. The regimentation of the youth of Germany did serve a purpose in that regard, but I do not think that we would be successful in doing it that way. But let us at least start on our teachers, give our teachers the lead; give them right ideas and then from the teachers down through the children in the schools. If they get the right conception and attitude towards these things and go on with the work from there and start immediately and do the best you can that way it will be to our advantage.

MR. FULFORD: Does it not all boil down to lack of education?

DR. LAMB: Yes.

MRS. CASSELMAN: With the normal schools as much as any other way.

DR. LAMB: Yes, because that is one place where the teachers are trained. When I refer to it in my brief I do not mean the training of teachers on physical education entirely. I should like to make it quite clear that it is just as important for all our teachers to have this conception as it is the specialized teachers who are going to carry it on.

MR. KINLEY: Mr. Chairman, I think this has been a splendid meeting of the committee. I like the physical fitness displayed in the presentation of the gentlemen who were before us; it shows they practise what they preach. It is true in Canada perhaps we need a lot of correction in the practice of making ourselves physically fit. But as I look back over the years to when I was a school-boy and look at the advantages which my children have in the public schools to-day, I think we have made great progress, and we see more and more the benefits of physical fitness. I think that is especially true of women. Those of us who are older remember the women of other days and the women to-day have gone through a revolution in physical fitness both in their activities and

many things that make for the more abundant life. I think there is one thing we should realize. Before people live well they must live. A start must be made with regard to the people who come out of the poorer homes, the people in our communities who do not have the advantages. The people who usually take advantage of physical training are the people from well directed homes. I have been connected with Boy Scouts and other groups down in Nova Scotia for a long time, and I find it is the boy with the good parents, who is well directed and disciplined from the start, who will take advantage of these things. We sometimes run across what we might call "emotional adolescence" where the boy's brain is developed more than his body, and that seems to bring about a condition that is not desirable. But I think we are on the road and I am glad to hear such men as those who have appeared before this committee to-day are interested in it. They know what they are talking about and they are enthusiastic about it. I should like to say, as far as I am concerned, I was immensely impressed with the presentations.

Hon. Mr. BRUCE: I would only like to say, Mr. Chairman, that I think the committee is deeply indebted to these gentlemen who have come here at a sacrifice of their money and time, to give us such excellent presentations on the subject. I am sure it cannot do other than assist us in the promotion of what we all have in view, a better chance for our young people.

Personally, I entirely approve of all I have heard this morning. I want to compliment my old friend and colleague, Colonel Dr. Ryerson, upon the rapid pace with which he went through a lot of stuff this morning. Some of the members of the committee perhaps could not follow him as closely as those who knew more about it, but I think when they read what he said and take the time to study it they will find he covered a tremendous field. We are all very interested in what the other gentlemen told us, and I cannot help but feel it will have a great influence upon the members of this committee in enabling them to come to a judgment to see whether they can influence the government to put a larger sum into this very worthwhile work.

The DEPUTY CHAIRMAN: If I may repeat some of the sentiments that have been already expressed, I think the committee is greatly indebted to the speakers who have been before us this morning, Dr. Ryerson, Dr. Lamb, Mr. A. A. Burridge and Captain Ian Eisenhardt.

I feel the committee appreciates very much the co-operation which you have shown in giving us the splendid material you have, gentlemen.

To-morrow there is to be a sitting of this committee, at which time there will be two briefs presented, one by a woman's organization and the other on venereal disease.

Is it the pleasure of the committee to adjourn now?

The committee adjourned at 1 o'clock to meet to-morrow at 11 o'clock a.m.

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Canada Social Security
Committee on 1943

SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

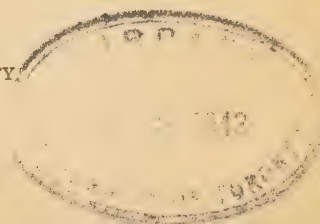
MINUTES OF PROCEEDINGS AND EVIDENCE

No. 15

FRIDAY, MAY 28, 1943

WITNESSES:

Mrs. Edgar Hardy, President of the National Council of Women;
Mme. P. E. Marchand, President of La Fédération des Femmes Canadiennes
Françaises;
Mrs. P. J. McGarry, President of the Catholic Women's League of Canada;
Lieut. Col. D. H. Williams, Chief, Division of Venereal Disease Control,
Department of Pensions and National Health;
Dr. Jules Archambault, Director, Division of Venereal Diseases, Ministry
of Health, Province of Quebec; and
Dr. Gordon Bates, General Director, Health League of Canada, Toronto;



MINUTES OF PROCEEDINGS

FRIDAY, May 28, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs.: Adamson, Casselman (Mrs.) (*Edmonton East*), Claxton, Donnelly Gregory, Howden, Johnston (*Bow River*), MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*) Macmillan, McCann, McGarry, Mayhew, Picard, Shaw, Wright. 17.

At the request of the Chairman, Dr. Heagerty introduced the following witnesses:—

Mrs. Edgar Hardy, President of the National Council of Women;

Mme. P. E. Marchand, President of La Fédération des Femmes Canadiennes Françaises;

Mrs. P. J. McGarry, President of the Catholic Women's League of Canada;

Lieut.-Col. D. H. Williams, Chief, Division of Venereal Disease Control, Department of Pensions and National Health;

Dr. Jules Archambault, Director, Division of Venereal Diseases, Ministry of Health of the Province of Quebec;

Dr. Gordon Bates, General Director, Health League of Canada, Toronto;

Dr. G. D. W. Cameron, Chief, Laboratory of Hygiene, Department of Pensions and National Health.

Mrs. Edgar Hardy was called. She submitted proposals of the National Council of Women of Canada.

Mme. P. E. Marchand was called. She presented resolutions passed by La Fédération des Femmes Canadiennes Françaises, and also a letter from Archbishop Vachon of Ottawa, approving said resolutions.

Mrs. P. J. McGarry was called and presented a resolution sponsored by the Catholic Women's League.

The Witnesses retired.

The following witnesses were called, examined and retired:

Lt.-Col. D. H. Williams,

Dr. Jules Archambault and

Dr. Gordon Bates.

At the Chairman's request, Dr. Howden took the Chair.

Dr. Bates' brief was ordered printed as Appendix "A" to this day's evidence.

Mr. Slaght requested Dr. Bates to file copies of the laws of the various states of the United States pertaining to compulsory examination before marriage.

The Committee adjourned at 1.00 p.m. to meet again on Tuesday, June 1st, at 11.00 a.m.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

May 28, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: This morning the topic of discussion will be certain resolutions of the national women's organizations. Dr. Heagerty, will you please introduce the representatives?

Dr. HEAGERTY: Mr. Chairman, Mrs. Casselman, and members of the committee, it is my pleasure and honour this morning to introduce to you Mrs. Edgar Hardy, President of the National Council of Women of Canada; Mme. P. E. Marchand, President of La Fédération des Femmes Canadiennes Françaises, and Mrs. P. J. McGarry, President of the Catholic Women's League of Canada.

I think, perhaps, Mr. Chairman, I might introduce the other representatives at the moment. We also have representatives from various parts of the country who will discuss the subject of venereal disease. They are represented by Lieut. Col. D. H. Williams, Chief, Division of Venereal Disease Control, Department of Pensions and National Health, the armed forces; Dr. Jules Archambault, Director, Division of Venereal Diseases, Ministry of Health of the province of Quebec; Dr. Gordon Bates, General Director, Health League of Canada, Toronto, and Dr. G. D. W. Cameron, Chief, Laboratory of Hygiene, Department of Pensions and National Health.

The CHAIRMAN: Mrs. Hardy, will you please come forward?

Mrs. EDGAR HARDY, President, National Council of Women of Canada, called.

The WITNESS: I herewith submit the statement of the National Council of Women of Canada on the question of national health.

Throughout the history of the National Council of Women of Canada one of the strong planks of our program has been public health in all its phases. We have supported all plans which we believe secured for the community as a whole the benefit of public health. In the post-war program, drawn up by a subcommittee of our organization and submitted at our meeting last May, we asked for the following:—

National Health and Nutrition

1. Dominion leadership, in co-operation with provincial and municipal health departments, in making provision for an adequate program of health, nutrition and child welfare for Canada, aimed at the prevention, control and cure of disease by such means as:—

- (a) A nutritional program ensuring diets adequate for health;
- (b) Strengthened and improved health services, through adequate health departments in all sections of the country, both urban and rural;
- (c) Adequate hospital accommodation for tubercular, mental and mentally-defective patients requiring institutional care;
- (d) Clinics for child welfare, heart disease, venereal diseases, cancer, tuberculosis and mental disorders;

(e) Medical care through:—

- (1) Extension of voluntary health insurance plans;
- (2) Appointment of municipal doctors;
- (3) A governmental plan of compulsory health insurance for those in the low income groups;
- (4) Free care for those not included in a governmental health insurance plan, who are unable to pay.

2. An extension of the voluntary health work carried on by various health agencies and by industrial medical services. The achievement of much of this public health can be secured by the following social insurances:—

1. An extension of benefits under the Unemployment Insurance Act;
2. The establishment of a national plan of contributory old age pensions;
3. The establishment of a national plan of compulsory health insurance, as indicated above.

At our annual meeting, June 16 to 19 inclusive—I may say, Mr. Chairman, that we have not yet studied the report of the Health Insurance Committee; I am trying to read it, but it is quite a long volume—we purpose to study this question as outlined in the health insurance plan as reported through the Department of Pensions and National Health's committee.

I can assure you at this time that we will support any plan in principle which will secure for Canada an adequate national health plan as stated above.

The CHAIRMAN: Are there any questions?

Witness retired.

The CHAIRMAN: Mme. Marchand, s'il vous plait?

Mme. P. E. MARCHAND: President, La Fédération des Femmes Canadiennes Françaises, called.

The WITNESS: I should like to present the resolutions passed by La Fédération des Femmes Canadiennes Françaises, and a letter written to Mlle. Julien by Archbishop Vachon.

[Translation]

Whereas morbidity and mortality rates show that the Canadian people is inadequately supplied with public health services and medical care;

And whereas the number of deaths due to tuberculosis is excessive and can be reduced through better prevention measures and free treatment;

And whereas there are too many cases of venereal diseases;

And whereas the prevalence of mental diseases and cases of mental deficiency, inadequately treated and cared for, constitutes a serious national problem;

And whereas persons in lower income brackets are unable to procure the needed medical, nursing and hospital care for themselves and their families;

It is resolved—

That the Fédération des Femmes Canadienne-Françaises request the Federal Government to grant financial aid to the provinces in order to enable

them to establish a health insurance organization which will provide complete public health services, as well as medical, surgical, nursing, and hospital care on a contributory basis.

Fédération des Femmes Canadienne-Françaises
affiliated with
The International Union of Catholic Women's Leagues

Ottawa, December 21st, 1942.

Miss Gilberte Julien,
Corresponding-Secretary,
Fédération des Femmes Canadienne-Françaises, Ottawa.

Madam:

In reply to your letter of the 14th instant, I wish to inform you that I endorse your resolution provided it is couched as follows:

Resolved—

That the Fédération des Femmes Canadienne-Françaises request the Federal government to grant financial aid to the provinces in order to enable them to establish a health insurance organization which will provide complete public health services, as well as medical, surgical, nursing and hospital care on a contributory basis.

Yours sincerely,

(Signed) ALEXANDRE VACHON,
Archbishop of Ottawa.

I just want to tell you, ladies and gentlemen, that we are all here for the same purpose. We have resolved to work and do the very best we possibly can on this committee. Our members are all waiting. Dr. Heagerty told me at the beginning, when I was invited to take the presidency of this French women's branch for some time anyway, that expenses were to be kept down as much as possible. The members who have accepted do not all reside in Ottawa and they have not been asked to come up here. I had a report from Mme. George Bouchard, and she says in Kamouraska county and all these places they are seriously studying, as well as the French branch of the Women's Institute. They are all interested in this work. At College de Saint-Jean there is a professor who has been studying this problem even in peace time. That also applies to Dr. Young. They are taking this thing into serious consideration and whenever they are called upon they will come.

Many people do not understand many of these things. We submitted our resolutions to the Archbishop of Ottawa, and I have already given his reply. Is that quite satisfactory?

The CHAIRMAN: Yes.

The WITNESS: Thank you very much.

The CHAIRMAN: Are there any questions?

The WITNESS: I think I should be the one to put the questions to the learned men who are here.

The CHAIRMAN: I will ask Mrs McGarry to come forward.

Mrs. MCGARRY: Mr. Chairman, ladies and gentlemen, I wish to thank you for having invited me to present this resolution, which is sponsored by The Catholic Women's League of Canada. The resolution is as follows:—

Whereas the maternal morbidity and mortality rates in Canada are higher than would appear necessary;

And Whereas the tuberculosis mortality rate is excessive and can be reduced by the provision of more complete preventive measures and free treatment;

And Whereas the occurrence of the venereal diseases is excessive;

And whereas the incidence of mental illness and mental deficiency together with inadequate medical care and treatment for these conditions constitute a grave national problem;

And Whereas people with insufficient incomes are unable to provide themselves and their dependents with adequate medical care, dental care, nursing and hospitalization;

Be it therefore resolved that The Catholic Women's League of Canada respectfully request the Dominion Government to take steps to assist the provinces financially in establishing a system of health assurance which will provide their citizens with complete public health services, medical, surgical, dental nursing and hospital care on a contributory basis;

Be it further resolved that the Dominion Government be requested to adopt the resolution of the Catholic Hospital Council of Canada.

The CHAIRMAN: I wish to thank the representatives of the women's organizations for their briefs and for their presence here to-day. Our next topic is venereal disease, and I shall ask Dr. Heagerty to say a word here.

Dr. HEAGERTY: I will ask Colonel Williams to take the stand.

Lt.-Col. D. H. WILLIAMS, Chief, Division of Venereal Disease Control, Department of Pensions and National Health, called.

The WITNESS: Mr. Chairman, Mrs. Casselman, members of the committee, it is indeed fitting that at a time such as this when national health in its broadest implications is being considered that the stepchild and Cinderella of public health, and indeed to my way of thinking, and I am not alone in this view, Canada's major health problem from the standpoint of public health, should be considered.

The problem of venereal disease and its control is a matter quite different when compared with the other medical problems that face our nation. It is quite different because it is an exceedingly complex problem, the roots of which lie deeply in inherent defects in human nature, in unwholesome community conditions, and in the failure of modern medical science to use the very effective weapons which have been at hand. The time for attacking this problem is long overdue. We have had the means whereby we might deal it a striking and effective blow. The time is ripe now if the people of Canada so will that venereal disease shall be banished. It depends upon the purpose of the people, seeing the problem and facing it from the standpoint of its true causal background—a by-product of unsatisfactory social and economic conditions—and the need for using these weapons of modern medical science.

Now, unfortunately, my association with venereal disease as a national problem has been relatively short—a matter of days or weeks almost—but it is very pleasant and satisfying to be able to present to a committee such as this some fairly satisfactory figures. One has to be exceedingly cautious in dealing with figures, and unfortunately our angle of this problem places me in a rather difficult position in that I know from certain glimpses of the picture that one sees that it is a major problem, and at the same time I cannot present details; but I am going to give you a few glimpses of the problem as we do see small parts of it, and I may be able to conjure up in your mind that glimpse of the problem. Mr. Cormier of the university of McGill, about three years ago estimated that the prevalence of syphilis in Canada was in the vicinity of 5 per cent. He meant thereby that at any given moment 5 per cent of the population

had syphilis. Now, that was a computed figure. I am always inclined to use figures in a conservative way, but if we say that the figure is out by 50 per cent the rate of prevalence may be, perhaps, nearly $2\frac{1}{2}$ per cent, and with that figure one would certainly not be erring in the wrong direction. It means that at the present moment in Canada you have approximately 287,000 people who have syphilis. Now, the tragedy is that we do know this definitely, that 65 per cent of those 287,000 people do not know at the moment that they have syphilis. The great tragedy of syphilis is its insidiousness, it creeps into our society, the strata of youth, and it remains there quietly without their knowledge often corroding and burning vital tissues and organs until in middle life or later the manifestations of it appear in the syphilis-riddle brain, the tattered, threadbare, worn heart, and so on, which cause such a tragedy in our land.

We do know that in our clinic each year—our public clinics throughout Canada 26,000 people attend for care. Our clinics are not attracting but a small percentage of the people who know they are infected, and if the doors of Canada's venereal public clinics are opening about half a million times a year to admit our citizens for the treatment of venereal disease, it is not hard to conjure up how many physicians' doors are opening up each year in Canada. And again the tragedy is how many physicians' and clinic doors are not opening to the 65 per cent of people that at the moment have syphilis but do not know that the tragedy dwells within their body.

From the standpoint of the death rate, again we are not in a very fortunate position statistically. Estimates would indicate that the death rate from syphilis in Canada at the present time is in the vicinity of from 6,000 to 12,000 per year. Let us take the last figure of 6,000. This means that in a period of ten years syphilis is killing the equivalent of the number of our citizens who lost their lives in the great war. It is certainly a major tragedy based on this very small mortality figure. But when we see the condition in its stark reality as a comparison with some other countries—Sweden for example—we are impressed. In the year 1934 in Sweden—in the whole of Sweden with a population just half that of Canada—they had reported 431 cases of syphilis. In 1939 in our public clinics we admitted 7,196. You can imagine how many went to private doctors and again how many didn't go who should have gone.

Let us take another little glimpse at this picture. We know that in the province of British Columbia with 800,000 people in a ten-year period from 1932 to 1942 396 middle aged men went into mental institutions with syphilis riddled brains. There is no reason to believe that the syphilis rate in British Columbia is any higher than it is anywhere else in Canada; in fact, there is every reason to believe it is perhaps a little lower because of the attention that has been given to the problem in the past five years there. If the British Columbia rate which, again, is very conservative, is interpreted in a dominion-wide way it means that in the past ten years 5,600 people have gone into mental institutions with syphilis riddled brains. Now, these few figures are just a glimpse at the picture. They may give you some idea what it means. This continuing, preventable tragedy of syphilis and gonorrhoea has been dealt with effectively elsewhere. The Scandinavian countries in twenty years reduced syphilis to a rare disease. In twenty years Great Britain cut its syphilis rate in half. What these countries have done Canada can do. We do not have to look to Europe in this matter. If we look to the south of us we will find that since 1936 the United States government has taken this problem exceedingly seriously and the developments there are very evident; they are showing, for the first time, the lowest military rates in the history of the United States. Those are very favourable and satisfactory rates from the standpoint of the white population. This has been done by a courageous campaign that has been led by Surgeon-General Parran, which has been endorsed by the public and put into effect by the representatives of the people.

To give you some idea of how they think the thing should be tackled in a financial way, the Bulwinkle-Lafayette bill was passed which provides for a federal expenditure on venereal disease, for the ten-year period between 1940 and 1950, of one quarter of a billion dollars. One quarter of a billion dollars to be spent federally on venereal disease in a ten-year period! Actually they have not been able to spend it all, they told me last week in Washington, the most they could spend last year was \$10,000,000. But it has got results.

In Canada I am sure that the public are aroused, and the very fact that a committee such as this can consider venereal disease in a comprehensive plan for national health is clear-cut evidence of it. One envisages for Canada, if we are to be effective in this tremendous problem, what one has termed Canada's four sector front against venereal disease. One sees these sectors as the health sector, the welfare sector, the legal sector and the moral sector—all sectors part of a line moving forward against venereal disease, each using its own personnel and its own peculiar weapons and techniques on its own front. One sees the physicians and nurses, hospitals, medical schools and health departments, with the weapons of modern medical science and public health procedure, going forward on the health sector. On the welfare sector, one sees the welfare agencies, welfare workers and other organizations interested in improving the welfare of our citizens, dealing with squalor, inanition, insecurity and so on. Then on the legal sector, we see the courts, the legal profession and police agencies seeking out those who are spreading venereal disease, or contributing to its spread and thereby adding to our national tragedy. Then finally, but not least, there is the moral front, which is participated in by the churches and the homes, strengthening the moral fibre of our nation and upholding the sanctity of marriage and family life. If we envisage a four-sector front of this nature, venereal disease is doomed. Each particular task, as one sees it on the health sector, is developing a strategy for this sector; and one has envisaged a six-point strategy which one would like to very briefly present to you.

This strategy is based upon the axioms—which are well known to public health—that syphilis and gonorrhoea are, among other things, communicable diseases, that they are vulnerable to the techniques of modern medical science, that they can be cured and that they can be prevented. These axioms constitute the rock foundation of the health sector front. The first point in our strategy is general education. The public to-day is avid for health education regarding venereal disease, in a wholesome, non-morbid way, and in a way that it never was before. The announcement of the result of the Gallup Poll two weeks ago which got the highest number of affirmative answers ever given to any question would indubitate that. The question was: Do you approve of the government engaging upon a health educational campaign regarding venereal disease? You have all seen the reply—2 per cent against it, 90 per cent in favour of it.

The first great need in Canada to-day is a wholesome, dignified educational campaign that will reach all our citizens with the facts, and banish the fallacies—and there are many of them still hanging on and enshrouding this problem of venereal disease. The second is adequate care, diagnosis and treatment. We must seek out and find the 65 per cent of people who have syphilis now and do not know it, because they are carrying with them the seeds of tragedy, of broken homes and married life, of congenital syphilis among little children. Extensive blood test campaigns are the only answer, because these people look just as healthy as you or I look at the moment, and they are quite unaware of their medical problem. The provinces during the past ten to fifteen years, have increased their budgets until at the present moment they are spending in the vicinity of about three-quarters of a million dollars on venereal disease. More needs to be spent. There is a great deal of activity

related to the improvement and management of provincial legislation going on now. That is all very favourable in helping the program. We must provide proper care and proper diagnosis for all our people.

The next point is that of quackery and charlatantry. The prejudice, the fear, associated with venereal disease drives countless thousands of young men into the hands of the quack—the man who, for a fee, returns nothing but what aggravates and perpetuates the infection. There are on all of the provincial statute books very effective laws to deal with this menace to the public health; but, with one or two exceptions, those laws are not being enforced. If they were, within two or three weeks they could wipe the foundation out from under the whole business of charlatantry and quackery associated with venereal disease.

The next point is the great tragedy—the greatest of all the tragedies in the realm of venereal disease—of the little child that comes into this world, through no fault of its own, with a little body honeycombed with syphilis. If they had the privilege of attending a Saturday morning clinic in one of any number of a hundred clinics across Canada and could see these little children coming in to receive their injections in their arms, week after week, for one year, two years, three years and some of them who have this in their brains, five years and longer, the pain it gives them, the anguish, the blindness, the mental deficiency and all the other disturbances of syphilis, the citizens of Canada would stir themselves so that the tragedy of pre-natal syphilis would be wiped out; and it could be wiped out by a very simple expedient within one year in Canada. It could be done if every expectant mother were to visit her physician before the fifth month and have a thorough examination, including a blood test; and if syphilis were found and treatment given, no matter how highly infected that mother is with syphilis, that little child could be born wholesome and free from infection. An almost 100 per cent guarantee goes with that, which modern medical science has only recently revealed. If the doctors will do their part and the women of Canada, the mothers of Canada, will do theirs by going early and having a blood test and proper treatment, there would be no need for one more case—not a single case—after a year from now. It is very simple. It is very necessary.

The next point is closely related. It is the problem of innocent infection in women through marriage. Syphilis insinuates itself, through the apparently healthy young man, into marriage. I feel that it is most important that the young people of the country be educated on a basis of going to their physicians before they anticipate marriage, for a general examination, including inquiry into the matter of syphilis, and that the results of the examination be known to both participants; that whether marriage takes place or not, advice be given, but the decision on the matter of marriage be left to the two participants, knowing all the facts.

The final point is that which deals with the spread of infection. Venereal disease is like the penny that, multiplied each succeeding day, doubles, and becomes at the end of a month a fabulous fortune—hundreds of thousands of dollars. A case of syphilis today is two in six months, four in a year, or maybe one hundred in ten years and maybe 20,000 in twenty years. If we can only find the contact of one infection and stop that contact, we may save the infection of countless people and the tragedy to home life which this means. So we are emphasizing the importance of finding the contacts.

Associated closely thereto are certain unsavory unwholesome community conditions that facilitate the healthy people towards highly infected sources—what is termed the “facilitation process”, association with people known as facilitators, and it centres around a number of pretty clearcut community conditions, and it is worth mentioning. The most flagrant is the so-called red-

light district, the nidus and primary focus of syphilis and gonorrhea in Canada. As long as they are supported, and as long as young girls from unfortunate homes and in difficult circumstances are exploited by third parties for money, we will always have venereal disease emanating to contaminate the wholesome influences of our family and home life in Canada.

Next we find, associated with certain cheap dance halls, certain hotels, certain taxi cab companies, certain restaurants, and certain massage parlours, community conditions that make it easy for our healthy youth to meet diseased youth and thereby carry the tragedy forth into Canadian national life. This is our sixth point.

One feels that if each sector does its share, and the health sector adopts this six-point program, with the exigency of war which has precipitated an acute problem, and if this subject is not permitted to lag when peace comes, the disease can be overcome. There is always the great danger of winning the war and losing the peace, and it applies particularly to venereal disease. I would say the only hope of a society interest, and a wholesome interest which will effectively banish venereal disease from Canada as it has been largely done in other countries, is the incorporation of provision for venereal disease and its control in any measure which is being considered for the betterment of national health; and I should like to make that suggestion.

(Brief appears as Appendix A.)

The CHAIRMAN: Thank you, Colonel Williams. Are there any questions, Mr. Minister?

Hon. Mr. MACKENZIE: No.

The CHAIRMAN: Have members any questions to ask?

By Mr. McCann:

Q. I should like to ask Dr. Williams this question. In view of the fact that the most important and accurate diagnostic measure that we have relative to syphilis is the Wassermann reaction—and of course it is impossible that such a percentage of the people as he has indicated may have had that—what is the basis of fact upon which the statement is made that 65 per cent of the population have syphilis?

Dr. HEAGERTY: He did not make that statement.

WITNESS: I did not make the statement that 65 per cent of the people have it, but rather that 65 per cent of the people that have it at the moment do not know they have it. That is the tragedy.

The CHAIRMAN: Are there any other questions?

By Mr. Wright:

Q. Is the Wassermann test used on recruits in the army? A. I am very pleased to say that, three weeks ago, general order 171 for 1943 authorized the policy of routine blood testing on enlistment of all men in the Canadian army.

By Mr. Donnelly:

Q. Before or after enlistment? A. That is immediately after enlistment and before they get their inoculations.

By Mr. Johnston:

Q. Would that apply to all the services? Would that take in the navy, the air force and the women's corps as well? A. The air force, I understand, has already adopted that. This applies to the army and to the C.W.A.C. I cannot speak for the navy.

By Mr. Wright:

Q. Does that apply to those already in the army? A. An attempt is going to be made to reach those who have not been tested. It is a task which is a colossal one, from the standpoint of providing facilities by the provincial laboratories. As a safeguard it is planned that, on demobilization at least, tests will be taken, so that the tragedy of syphilis returning to home life such as happened after the Great War, shall not happen this time.

Hon. Mr. MACKENZIE: We have taken these blood tests in our department since the beginning of the war, as you know.

The WITNESS: Yes.

By Mr. Slaght:

Q. One of the other members asked a question which I had in mind, but a further one occurs to me, Colonel. Have you the figures on rejections in the American army? There are figures. I have seen them somewhere in the press. I wondered if you could give them to us. A. I have those, I do not know the details. I can make them available to the committee in the form published by the American War Department.

The CHAIRMAN: Thank you very much.

By Mr. McCann:

Q. What is the procedure in the army where you have a test which shows positive? Are those men inducted and treated, or are they rejected?—A. We divide syphilis into two main types of infection: the serious deep types involving the heart, liver and nervous system; and the more superficial, relatively benign types. The former types, the deep serious ones, are excluded because they require a highly technical type of treatment. The other types are taken in and given good treatment.

By Mr. Donnelly:

Q. In this report that is handed out here, I notice the cases reported in the Toronto General Hospital in 1939, 1940, 1941 and 1942 have increased. Do you think that the war is the cause of that increase, or what do you think?—A. That is Dr. Bates' material.

The CHAIRMAN: Dr. Bates will answer that question when he comes on later, I understand.

By Mr. McGarry:

Q. In cases where syphilis is diagnosed in the armed forces, are those infected isolated or segregated?—A. That is a rather technical question. It is an important one, however. The question of infectiousness of venereal disease is a relative one. Gonorrhea is not infectious at all for the ordinary casual contacts of life. If it were, we would all have had gonorrhea long ago. Syphilis is communicable for about twenty-four hours after the first injection, and they are isolated for a few days. Thereafter, they are not infectious for casual every-day contacts, even while under treatment.

The CHAIRMAN: Are there any other questions?

Mrs. EDGAR HARDY: Yes, Mr. Chairman. All these questions seem to be aimed right at the armed forces. Our organization last year sent a resolution to the government asking if, when men were rejected on coming up for enlistment, there could be an arrangement made whereby they were told why they were rejected. I think that we can feel, pretty generally, that the men and women in the forces are being looked after. It seems to me that it is the general public

and the community at large that we need to educate and train. We have never had a definite response to that request as to whether the men or women on enlistment would be given a definite statement as to why they were rejected; the idea being if they were rejected on account of venereal disease, they would be told that, and arrangements made for treatment.

The CHAIRMAN: Do you care to comment on that, Colonel Williams?

The WITNESS: That question involves two bases; one of which is where the man is already in the service. If he is rejected for venereal disease when in the service, a letter is sent to the health department and he understands all the details. If he is rejected at the time of enlistment, he is told the reason and is advised to go to his private physician.

The CHAIRMAN: Thank you, Colonel Williams.—The Witness retired.

The CHAIRMAN: We shall now hear Dr. Archambault, Director of the Division of Venereal Diseases in the province of Quebec, Montreal.

Dr. Howden, will you please take the chair?—Dr. J. P. Howden takes the chair.

Dr. JULES ARCHAMBAULT, Chief, Division of Venereal Diseases, Ministry of Health of the province of Quebec, called:

The WITNESS:

THE PROBLEM OF SYPHILIS IN THE PROVINCE OF QUEBEC IN 1943

The campaign waged against venereal diseases, in the province of Quebec, dates from 1920. It led, among other things, to the following results: the establishment of dispensaries some of which have become notable study and information centres; the organization of a laboratory of serology where, in the course of the year 1942 217,000 samples, including 4,200 cephalorachidian liquids, were examined. To carry out such a number of examinations we use, for the blood, the Kline eliminatory reaction test, and every sample which this test proves positive or doubtful, is subjected again to other tests, the Wassermann and Kahn tests.

In the course of 1942, the serological examinations yielded positive results in a total of 18,000 blood samples. However, conclusions cannot be drawn with respect to the number of syphilitics who were disclosed or exist in the province of Quebec.

As to the prevalence of this infection in the province of Quebec, the reports of our dispensaries and other data led us to conclude, in 1939 and 1940, that there are no fewer than 120,000 syphilitics, and that in mining and industrial centres, where 60 per cent of our population are concentrated, the percentage rate of syphilis reaches 6 per cent, the same ratio as in similar centres in the United States.

We had no definite statistics to draw upon in establishing these figures, since the reporting of syphilis has only become compulsory since 1941, and 1942 is the first complete year for which we were able to secure this information from physicians.

The number of syphilitics treated in clinics and hospitals in 1942 was 6,305 as compared with 6,138 in 1941 and 6,964 in 1940. Thus, on the whole, the total remains virtually unchanged.

On the other hand, we note a sharp increase in the number of syphilitics treated and reported by physicians. These cases which numbered 1,029 in 1940 increased to 2,092 by 1941, and this latter figure more than doubled in 1942, the total rising to 4,348.

According to our statistics, there were all-told, 10,653 syphilitics treated by clinics and physicians in 1942. As it must be admitted that a rather substantial number of these afflicted persons were treated without being reported to our division, we are quite certain that more than 12,000 syphilitics were treated during this same year. Now, if one agrees with Dr. Parran, that the number of syphilitics under treatment only represents 10% of the individuals infected, the number of the latter in our province reaches a total of 120,000.

Should one now attempt to establish the rate of incidence of new infections through syphilis, amongst our population, according to the statistics for 1942, we note the following reported cases: 1,345 cases of primary syphilis, 1,234 cases of secondary syphilis, or a total of 2,579 recent infections representing a rate of incidence of about 0.73 per 1,000 people.

Moreover, one must take into account the older infections which were discovered and reported during the year 1942. We note in this connection 887 latent infections of less than four years, 726 in existence more than four years, 256 cases of tertiary syphilis, 408 cases of nervous syphilis, or a total of 2,277, approximately the same number as that of primary and secondary infections.

One must admit that, notwithstanding a very close check-up made during the year, there remain primary and secondary infections that are unknown, and that all those that were discovered were not reported to our division.

Cases coming under these headings form a total which we estimate to be equal to that of latent infections of less than four years, reported in 1942. These 887 infections added to the other recent infections raise to 1 per 1,000 the rate of incidence of syphilis among our population. Admitting that, we believe we are below the actual figure. The danger of venereal diseases gives rise to much greater alarm if one notes the increase in the number of recent infections reported by institutions during the years 1940, 1941 and 1942. The number of primary infections rose from 300 to 400 in 1941 and totalled 540 in 1942; that of secondary infections stood at 365 in 1940, 560 in 1941 and 660 in 1942. In other words, recent infections showed an increase of 80% in two years.

That increase would probably be less marked if we had not established in our principal anti-venereal clinics since 1941 a social service which not only contributed in keeping patients under treatment but also in tracing the source of their infection.

Our act respecting the prevention of venereal diseases and the regulations made thereunder have been in force since March and June 1941. The epidemiological rules followed in connection with the discovery and control of the other infectious diseases apply henceforth to syphilis, and the establishment of a medico-social service constitutes the most important measure adopted by the Health department for the control of venereal diseases.

This service comprises a director and 18 specially trained assistants who are permanently attached to the large Montreal and Quebec clinics and to the dispensaries at Trois-Rivières and Sherbrooke. Nurses of our health units are attached to a few other dispensaries. The physicians associated with these units and regional inspectors acting jointly with us when necessary, extend our medico-social service to the whole province, but one of the most urgent measures is undoubtedly that which calls for the increase in the number of our female medico-social assistants, in order to be able to assign one to each of our industrial centres.

The number of clinics subsidized by the venereal diseases division totals 10 in the City of Montreal, Verdun included, 4 in Quebec, and 6 in the other most important centres, a grand total of 20 clinics.

The most important clinic treated 1,500 syphilitics, three treated from 500 to 600, four from 200 to 300. On the whole, all the clinics and institutions treated, as we stated, more than 6,000 cases in 1942.

These clinics administered 138,921 injections of arsenic, bismuth and mercury supplied by our division.

Our free distribution of anti-syphilitic medicine to physicians started prior to 1941, but it assumed real importance in 1941 with the distribution of a total of 63,820 doses of injectible medicine.

During 1942, physicians received from our division more than 64,000 phials of 914 and other arsenical preparations, and a sufficient quantity of bismuth and mercury for more than 60,000 injections forming a total of 125,000 treatments.

Our free distribution of medicine for blenorrhagia amounted to more than 140,000 grams of sulphamides, of which 9,000 were supplied to physicians treating paupers in districts where there is no dispensary.

The 4,000 cases of blenorrhagia treated in our dispensaries represent but a slight proportion of infections by gonococcus, most of these cases being treated in private offices without being reported to our division. But we have every reason to believe that the rate of incidence of blennorrhagia is greater than that of syphilis, just as it is generally disproportionate elsewhere.

The reporting of all venereal diseases is compulsory but we insist particularly on that of syphilis, by reason of the gravity and duration of this infection. We resort to two methods to ensure reporting: 1, all anti-syphilitic medicine is refused for the treatment of a patient the report of whose case is not in order; 2, positive serological results reported by our laboratory to the physicians serve to control their reports. When a positive result corresponds with a non-reported sick person, his physician receives a notice, followed by a second if needs be.

The collaboration existing between the physicians and the division of venereal diseases is a matter of great encouragement and a factor making for success. We have striven from the outset to develop this collaboration by maintaining an advisory service capable of helping physicians by guidance as to treatment or in the interpretation of the serological reactions.

The measures taken by the Health department with a view to promoting instruction and treatment in the matter of venereal diseases provided for the organization of centres under the direction of the teaching staff of Montreal, Laval, and McGill Universities.

Apart from the university instruction, these centres serve to train our health doctors and social workers. They also receive all paupers afflicted with venereal diseases for purposes of diagnosis and treatment. And lastly, with the approval of the Attorney General, the staff of these centres has undertaken the treatment of the women confined in the Montreal and Quebec prisons.

In the case of paupers afflicted with syphilis not requiring hospitalization and living in districts where there is no dispensary, the treatment which their condition calls for is entrusted to the nearest physicians who receive a certain compensation for this service from the health department.

The first report of our medico-social service will convey an idea of the results to be expected from it.

During the year 1942, 682 sources of infection were reported to our division; our investigations traced 77 per cent, and three-fourths of the persons examined showed obvious traces of syphilis or blennorrhagia, or of both infections.

Our principal dispensaries reported 590 persons as contact cases; all less 1 per 100 were traced, and about one-half were suffering from syphilis. Of these 266 syphilitics, 95 per cent were brought to treatment. Thus, there remains only 5 per cent of such sick persons whom we were unable to follow up.

Congenital syphilis was sought amongst 571 persons born of syphilitics. It was established that 328 were suffering from the disease and 294 of these heredito-syphilitics, that is 89 per cent, are being treated.

The work of our medico-social service was especially fruitful in the clinics in keeping the afflicted persons under treatment. However, 610 were reported to us as delinquents and 491.79 per cent were traced. Of the latter, 95 per cent, that is 465 infectious syphilitics, were brought back to undergo treatment. Legal

proceedings were required in the case of only 41 individuals of whom 31 were taken to prison and 9 isolated in hospitals. These severe measures applied to but 9 per cent of the total of delinquents.

We do not include in these figures the segregation orders issued with respect to about 600 persons arrested as prostitutes or street-walkers and found to be infected with syphilis or blennorrhagia.

By reason of the number of persons afflicted and the increase in recent infections ascribable to the war, syphilis and blennorrhagia constitute a serious problem for which the Province of Quebec has been striving these past two years to find a definite solution.

1. The 1941 legislation makes the reporting of venereal diseases and their treatment compulsory as long as they are contagious, and it also authorizes their segregation.

2. A medico-social service is charged with the task of locating the sources of infection and to keep the infectious persons under treatment.

3. The treatment is free in the case of paupers and facilitated for all syphilitics through the distribution of medicine.

4. Our laboratory maintains a high standard for all examinations in connection with syphilis.

5. Medical instruction is organized for students and practitioners.

6. Propaganda work is carried on by means of the radio, films, posters and the distribution of hundreds of thousands of pamphlets.

These propaganda and control measures cost the Province of Quebec a sum of 100,000 dollars for the current year, and they have not yet reached a point of development that would ensure their full effectiveness. Additional grants doubling our present budget will be required for the social service, the treatment of paupers, propaganda work. We suggest that the central division pay these grants to our division of venereal diseases. The Department of Pensions and National Health should thus contribute a sum equal to that allocated by our province for the battle being waged against venereal diseases a battle which interests the nation as much as our province.

The ACTING CHAIRMAN: It may be that many of us have not been able to follow Dr. Archambault as we should like. Are there any questions?

Hon. Mr. MACKENZIE: I should like to ask Dr. Archambault a question.

By Hon. Mr. Mackenzie:

Q. You have been engaged in this work for a great number of years. Has there been any reduction in the incidence of the disease in your territory since you commenced this work?—A. I have been attached to the laboratory mostly. It is only two years that I have been attached to the Division of Venereal Diseases. In those two years it has increased to a very remarkable degree. There has been a very remarkable increase in the incidence. I think I am safe in saying that the number of recent infections has jumped 80 per cent in two years.

Q. Would that be caused by war conditions?—A. We think so, because just before the war there was rather a reduction. When I go back to the old reports of the department I find that there was a reduction.

The ACTING CHAIRMAN: Are there any other questions?

Thank you, Dr. Archambault.

—Witness retired.

The ACTING CHAIRMAN: The next witness is Dr. Gordon Bates, General Director, Health League of Canada, Toronto.

Dr. GORDON BATES, General Director Health League of Canada, Toronto, called.

The WITNESS: Mr. Chairman, ladies and gentlemen, a brief covering the question of education in connection with venereal disease control is in the hands of each member of the committee and is as follows:

The question of venereal disease has been considered to be the most serious and the most difficult of all public health problems. The facts as to its seriousness became evident with the general use of the Wassermann reaction towards the beginning of this century. Sir William Osler before he died made the statement that syphilis outranked all other infections as a cause of death. Subsequently syphilis became known as "the great killer". Gonorrhoea, even more prevalent, was characterized as "the great sterilizer" from its effects in cutting down the birthrate.

British Royal Commission (1913)

The inroads of these two diseases in Great Britain resulted in the formation of a royal commission in 1913 which brought in its report in April, 1916, resulting in the development of a program involving the expenditure of vast sums out of the imperial treasury for the reimbursement of health authorities entering into treatment schemes. A very important part of the program was the formation of the National Council for Combating Venereal Diseases, a voluntary association under the presidency at first of Lord Sydenham, the chairman of the royal commission. This association was partly subsidized by the British government.

CANADIAN PROGRAM

Ontario Royal Commission

Similarly in Canada as the result of a gradual appreciation of the dangers of these diseases specific steps were undertaken during the last war. For example,* a royal commission in Ontario, under Mr. Justice Hodgins, drew up the first concrete, comprehensive legislation, although an order in council preceded this in Saskatchewan.

Canadian Program (1919)

In 1919 as the result of a dominion-wide conference called by the then president of the Privy Council, the Honourable N. W. Rowell, later first Minister of Health for Canada, a program was developed in Canada. This involved the first and only grants for health purposes to be given to the provinces by the dominion government for any purpose, amounting to \$200,000 under certain conditions, one of the most important of which was that in each province an amount equal to the dominion grant should be spent in addition. The conference also decided that a division of venereal diseases should be formed in the dominion government and that a new voluntary association, similar to the British National Council for Combating Venereal Disease, should be formed. Incidentally the development of a venereal disease program through this conference came almost concurrently with the establishment of the federal Department of Health under a separate minister and doubtless the venereal disease problem with the need for federal subsidy had much to do with the precipitating of the formation of the federal Department of Health.

Social Aspects of the Problem.

The venereal diseases have been aptly referred to as social diseases because to a degree they are a symptom or a result of social conditions. Hence the field of venereal disease control has been referred to as the field of social hygiene and a social hygiene program is necessary to control venereal disease. For example, in spite of the fact that venereal disease may be both prevented and cured by purely medical means, medical means alone will not control them. The Archbishop of Canterbury, President of the Central Council of Health Education of Great Britain, in a recent statement said that government officials had ignored the moral principles underlying the subject of social diseases. "The root of the trouble", the Archbishop said, "is the treatment of what is primarily a moral problem as if it were primarily a medical problem. What is primarily a moral problem with a medical symptom is being treated as if it were primarily a medical problem with a moral aspect". This is a repetition of a similar statement made a year ago by Dr. James McIntosh, until recently Chief Medical Health Officer for Scotland.

Education on Medical Facts

In view of this fact it becomes obvious that in discussing the subject of education one must approach it from a number of different angles. It would seem obvious that the medical angle must come first. The thing which has preceded programs for the control of venereal disease has been the spreading of information as to the fact that venereal diseases are prevalent and serious. It was an educational program emphasizing such facts, carried on by groups of interested citizens between the years of 1916 and 1919 which resulted first in the passage of legislation in Ontario and later the conference called by the Hon. N. W. Rowell on May 19, 1919, to establish a dominion-wide program for the control of venereal disease.

Scientific Discoveries

Undoubtedly the discoveries of science, notably the discovery of the spirochaeta pallida—the cause of syphilis, by Schaudinn in 1903 and the discovery of the Wassermann reaction by Wassermann in 1906 were very largely responsible for all later developments. It was only the fact that the diagnosis of syphilis was made easy by the development of this blood test which made it possible to obtain concrete information as to the ravages of syphilis, which resulted in getting any action at all. The following are some of the facts with reference to the disease, syphilis, gleaned from pamphlets issued about 1920 on this subject:

Statistics of 1920

Gonorrhoea Causes:

- More than 10 per cent of all blindness.
- Eighty per cent of the new born blindness.
- Many chronic diseases of joints, bladder and generative organs.
- Fifty per cent of surgical operations on the female, generative organs.
- It is easily seen that it reduces earning capacity.

Syphilis is the cause of a large percentage of all insanity.

- It causes locomotor ataxia and paresis or softening of the brain.
- It is the chief cause of apoplectic and paralytic strokes in early life.
- It is the cause of nearly half of the abortions and miscarriages.
- It is the cause of a large proportion of diseases of the heart, blood vessels and other vital organs.

It is transmissible to the offspring and causes death in a very high percentage of those infected.

It is one of the causes of mentally defective children.

Syphilis greatly decreases earning capacity and shortens life about one-third.

Prevalence of Syphilis

It is pointed out here that routine blood tests between 1916 and 1918 in Toronto General Hospital showed that 12·8 per cent of all patients gave a positive Wassermann reaction, indicating the presence of syphilis, and in Montreal General Hospital no less than 26 per cent. It is noted that even today there are some parts of this continent and certainly other parts of the world in which the percentage of syphilitic infection is much higher. For instance, not long ago, the chief officer of health for Alabama, made the statement that surveys of conditions in Alabama showed that syphilis ran as high as 40 per cent of the populations in some towns. On the other hand in other countries and in places where vigorous campaigns have been undertaken, syphilis has been reduced almost to the vanishing point.

Mr. N. W. Rowell, in a debate in the House of Commons in 1919, made the statement that in one Canadian insane asylum syphilis ran as high as 24 per cent of all male admissions in a single year. This has been reduced of course, very materially since.

It was recognized as I have suggested that the problem of venereal disease was so great and so intricate and involved so many organizations and institutions that the educational phase of the control program should involve the active co-operation of a voluntary association which could be used to bring all of these associations together and influence them all. For this reason, both in England and in this country a voluntary association formed a very important part of the picture.

Formation of Voluntary Association (1919)

The voluntary association in Canada came into being in 1919. It included representatives of all of the different provinces and carried on under the name, National Committee for Combating Venereal Disease, for one year. At the end of a year the name in Canada was changed to Canadian Social Hygiene Council. This was in recognition of the fact that we are dealing with a social problem.

Education of the public

When it came to discussing just what education should be undertaken it was found that the first type of education must be education of the general public on the facts about venereal disease. It was known and is known that thousands of people suffer from syphilis, for example, without knowing it. This may be due to ignorance of the symptoms to expect. It is very largely due to the fact that syphilis may exist without any symptoms for many years, in spite of the fact that the disease may cause widespread disability and death. Therefore, the first task was to develop means whereby large numbers of the population could be educated at once.

"End of the Road" film

One of the first educational steps undertaken was entering into a contract to show a very valuable moving-picture entitled, "The End of the Road". This picture was shown immediately throughout Canada to about a million people with a wide distribution of educational literature.

Special Speakers: Dr. J. J. Heagerty, Mrs. Emmeline Pankhurst

Another extremely interesting development in the campaign against venereal disease in the early days was an arrangement made with various provinces whereby Dr. J. J. Heagerty, the General Secretary of the League and Mrs. Emmeline Pankhurst toured Canada, addressing large meetings on the subject of venereal disease in all its aspects—social, moral and medical. Methods of this type are of considerable value because they make it possible to deal with the subject in a comprehensive way.

At that time we suggested to the United States we would like to take Carnegie Hall and send these three speakers over there because of the enormous audiences they have received in Canada, but at that time public opinion was not ready, and it is interesting to note that it was not until Dr. Parron got started that in New York city their newspapers would mention syphilis.

Results

The moving picture to which I have referred proved its value from the medical point of view in that in every city in which it was shown there was an immediate demand for examination or treatment by large numbers of people. The meetings addressed by Mrs Pankhurst, Dr. Heagerty and the general secretary of the association, had another effect in that they stimulated interest on the part of churches, social organizations, etc., to deal with the fundamental social factors resulting in the spread of disease. This type of work, namely, the use of the established media of education, has been carried on to some extent by the voluntary association ever since.

Education facilities in Clinics

I should say a word here as to the value of the clinic itself as a means of education. Undoubtedly the fact that we now have clinics in every province of Canada to which people may come, not only for treatment but to learn of the seriousness of the disease and spread information, has been a factor in keeping the disease under control. The fact that the dominion Department of Health up until the time of the discontinuance of dominion grants and the provincial departments of health have distributed literature in clinics, has also been of help.

Dominion Responsibility

But it was soon found that in addition to the education of the people as to the facts of venereal disease another serious matter must be dealt with. In the making of grants by the dominion government for the control of venereal disease throughout Canada, a new principle was recognized, namely, that the dominion government has a responsibility in the field of health. We forgot that in order to keep the venereal disease control scheme for Canada intact it was necessary that legislators be kept informed. In other words, there was a field of education in the House of Commons itself.

The proof of this is that in 1925 the dominion government decided to do away with the venereal disease scheme altogether insofar as the dominion was concerned. In view of the fact that such action would have destroyed the scheme as a coordinated whole it became necessary for the voluntary association to act. First a large and representative deputation, organized by the voluntary association, met the dominion cabinet and urged to no avail that the scheme be not interfered with. The deputation was told that the question of disease control was purely a provincial responsibility and nothing could be done about it.

Voluntary Committee on Health of the Senate and House of Commons

The result was that the voluntary association was given the duty of organizing in the House of Commons. After every member of the Senate and the House of Commons had been contacted personally a committee was formed under the chairmanship of the late Senator Rankin. The committee included some of the most outstanding members of parliament of that date. This committee took a deputation of fifty members of the house to meet the Prime Minister with the result that the decision of the government was reversed, grants to the provinces were maintained, the grant to the voluntary association was increased and the campaign was continued until 1932. In spite of all efforts in 1932 the then government again decided that the scheme should be scrapped. All grants were withdrawn and there was no further action by the dominion government until 1938.

Following the discontinuance of the grant the voluntary association now known as the Canadian Social Hygiene Council, with no money in the form of grants, was compelled to rely entirely upon public support. During this period the picture, "The End of the Road" was revived and shown to several hundred thousand people and later in 1933 the picture, "Damaged Lives" was produced in Hollywood and shown in Canada immediately to about a million people and later to all English-speaking countries in the civilized world and to many foreign countries.

The picture had a great deal to do with reviving interest in the subject and in 1938 a grant of \$50,000 was inserted in the estimates for the purchase of drugs. A grant of \$5,000 was given to the Canadian Social Hygiene Council (now the Health League of Canada) for general health purposes in 1935. This annual grant stands at this sum now although for several years previous to 1932 this grant had stood at \$20,000 annually.

During all of the period from 1925 the parliamentary committee of the Senate and the House of Commons has met from year to year. The subject of venereal disease has been constantly a question on the agenda and since 1932 when dominion grants were done away with both the parliamentary committee and the voluntary association, now known as the Health League of Canada, have constantly worked to have the scheme restored with all of its component parts. The present parliamentary officers of this committee are: Dr. J. P. Howden, M.P., Chairman, Dr. J. J. McCann, M.P., vice-chairman, and Dr. C. J. Veniot, M.P., parliamentary secretary. The general secretary of the Health League of Canada has been active secretary of the committee since its establishment in 1925.

As you all know there are items in the dominion estimates this year amounting to \$240,000 as follows:—

- (1) \$175,000 in grants to the provinces
- (2) \$15,000 for the establishment of a venereal disease division in the Federal Department of Health
- (3) \$50,000 for the purchase of drugs for distribution in the provinces.

So that actually the amount of money made available this year is greater than in the first place. No provision has been made for increased grants to the Health League of Canada for propaganda and education.

United States Government Program

It may be of interest to members of the committee to know that under the Lafolette-Bulwinkle Bill passed by the United States government a program similar to the Canadian campaign was made possible and the giving of grants by the federal government up to \$25,000,000 a year authorized. I am informed that the total expenditure by the federal department last year (1943) was \$8,000,000 and that the expected expenditure this year will be \$15,000,000.

Even after taking into consideration the difference in population between the United States and Canada they are spending seven or eight times what we are spending even now.

Re-establishment of Dominion Program

You are also probably aware that Colonel Williams who is here today has become Director of Venereal Disease Control in the army and assumes a similar position in the Department of Pensions and National Health. Therefore for the first time since 1932 it will be possible to develop a co-ordinated program as between the dominion, the provinces and the public at large.

When it comes to the question of education it is necessary to consider who to educate and how. A program of popular education similar to that undertaken at the time of the originality of the scheme is desirable. As a matter of fact to some extent such a type of education has been carried on by the voluntary association.

The Health League of Canada during the last six months has shown a very valuable educational picture throughout every province in Canada to over half a million people. Literature has been distributed and other films shown on a modified scale both to the civilian population and to members of the armed forces. At the moment ten copies are in use both in the civilian population and in connection with the armed units. Some of the pictures are on loan to the army.

But it seems to me that this type of education is only a start. It teaches largely medical facts to somewhat restricted groups. It will be necessary to recognize the fact as I have suggested that there are more phases to the subject of venereal disease than merely the medical phase and therefore an attempt must be made to contact all groups in the community.

Colonel Williams has described a 4-point program as follows: Medical, moral, welfare (or social), law enforcement.

EDUCATIONAL PHASE

Education of Physicians

In discussing the medical phase alone one finds that more than the public need to be approached. The advances in the scientific treatment of venereal disease have been so rapid that even some physicians have been left behind. In the absence of intensified post-graduate education on this subject some attempt must be made to keep physicians throughout the country informed as to the most recent developments. An attempt has been made in this direction by the Health League of Canada through the organization of a Medical Committee under the chairmanship of Dr. Robin Pearse in Toronto, which for more than a year worked on the development of a text-book on the subject of syphilis and gonorrhoea. This booklet of 84 pages was an attempt to bring up to date all knowledge on the subject of treatment of venereal disease. This book has been distributed gratis to physicians both in and out of the armed forces by the Department of Pensions and National Health and the provincial departments of Health.

Education of Nurses

Similarly in schools of nursing a set of lectures for the education of nurses has been valuable but these lectures should be brought up to date and given general distribution.

General Education

In discussing the educational phase of this problem it is well to recall the four different sections which Colonel Williams has described as a program, as to some extent they overlap. Medical investigators, for example, have discussed

certain conditions of a purely medical character which it would seem could only be controlled by legislation; for example—second generation syphilis presents a serious problem. The following case will illustrate this.

The other day a man walked into the city relief office of a Canadian city with the statement that he was suffering from rheumatism and could not work. This man, when referred to hospital for medical treatment, was discovered to be suffering from late syphilis. On investigation it was found that his wife was infected and the following is the history of the children:

1st child—partially blind and deaf

2nd and 3rd children— deaf and dumb

4th child—a cripple with a long bone syphilitic infection

5th child—an idiot

6th child—mentally defective

7th child—18 months old and syphilitic

It would seem that this condition could only be corrected by medical examination before marriage. In a number of cities in the American union a law enforcing such a procedure is on the statute books.

Medical Examination before Marriage

Undoubtedly an educational program informing people that marriage should not be entered into lightly and that medical examination before marriage is desirable, would seem to be logical. In this connection the use of the blood Wassermann on all expectant mothers might also form part of an educational program.

Routine Wassermann in Industry and in Hospitals

This immediately leads one to think of a number of employed persons who may be suffering from syphilis and may break down under the stress of work. Thus an educational program directed towards industry would seem to be logical. Such a program might suggest the pre-employment and periodic examination of employed persons and that such an examination should include a routine Wassermann reaction. Then there is the whole question of the education of physicians and hospitals of a more wide-spread use of this test in order to detect cases of syphilis which otherwise would not be discovered until serious damage had resulted.

It is a matter of congratulation that the importance of this test has been realized by the military authorities and that Colonel Ralston, the Honourable Minister of Defence, has recently announced that the test will be generally used in the army in the future. It is hoped that this examination includes all recruits and not only those acceptable for military duties. It is suggested that those unacceptable for other reasons, if syphilitic, are just as liable to become a charge on the public purse in future years as are those whose physical standards are such that they are acceptable for military duties. My understanding is that less than fifty per cent of applicants for medical service are accepted.

LEGAL PHASE

When there are legal phases to the above the general question of law enforcement in connection with venereal disease has to do on the whole with other matters. There is the question of adequate general legislation for the control of venereal disease. Reasonable adequate legislation of this type now exists in nine Provinces. Such legislation is changed and improved from time to time.

Types of Legislation Needed.

Then there is the question of laws for the control of prostitution and all the conditions which encourage illicit contact and the spread of disease. It would

seem that preceding steps to procure adequate legislation one should have facts. We are already in possession of facts which tend to indicate that venereal disease, particularly syphilis, is on the increase in the civilian population. Fact finding explorations on the part of local committees would reveal a good deal.

However, we are aware now that in many parts of this country not only is there the problem of organized prostitution but other means for facilitating illicit contact exist, for example, the use of hotel rooms. We have many cases in which infection has been contracted in a hotel in which an unmarried couple is allowed to register without any interference on the part of the proprietor. It would seem that the question of law enforcement and education are pretty closely connected here. Law enforcement in this respect should follow a public demand for action and a public demand for action will not result except from the placing of the facts before responsible citizens who will demand action.

Laws may be necessary for the regulation of taxi cabs and for hired automobiles, dance hall ordinances may be necessary, rooming house and hotel licensing laws may be necessary. All of these presuppose accurate knowledge of the facts and some publicity if results are to be achieved.

MORAL PHASE

It has been said that the moral phase of this problem is the business of the church and doubtless the church has a very serious responsibility. The moral phase is also the business of the home. There is no doubt that the sex delinquent on the whole becomes delinquent, not so much from the lack of knowledge as to the function of sex but from failure on the part of the church, home and school to inculcate sound moral principles.

Morals and the Church.

It is suggested that if the church is to act the medical authorities have facts as to social conditions which should be in the hands of clergy if they are to act intelligently. Probably the Archbishop of Canterbury is not far wrong when he states that this problem is essentially a moral problem with medical symptoms. Its solution would seem to require the co-operation of medical authorities religious authorities and educational authorities all working together.

SOCIAL OR WELFARE PHASE

The fact that at the present time society is pretty well dislocated by conditions of war accentuates the seriousness of the problem. Thousands of young people living far from home and removed from the normal restraint of a home and family life are much more likely to get into trouble than would be the case under the normal conditions of peace.

An American Program

During the last war this fact was recognized particularly in the United States where as a means of control a program was evolved requiring the co-operation of all of the great national associations, with the public health and army authorities. The Training Camp Activities Commission in the Army, under the direction of Mr. Raymond B. Fosdick, now president of the Rockefeller Foundation, involved the co-operation of the great national welfare associations such as the Y.M.C.A., Y.W.C.A., the K. of C., the American Library Association, etc., with a view to providing what were called the normalities of life for the American soldier. Some such scheme would be apt in Canada today.

The whole problem of the delinquent boy and girl and what society can do to reduce delinquency is a part of this problem.

Means of Education.

Obviously the accepted means of education must be utilized in an attack on this problem on a nation-wide scale. It must be made possible to utilize the informed speaker, the pamphlet, the moving picture, the radio address and the press. Some of the prejudice which has made it impossible to discuss venereal disease over the radio should be attacked.

A problem which unsolved fills our mental institutions and our hospitals with thousands of people who are ultimately a charge on the public purse, surely demands that we should forget the prudery which in the past has forbidden its public discussion. Undoubtedly the words "venereal disease", "gonorrhoea" and "syphilis" should become as common place as the word "measles" or "tuberculosis". I believe that a scheme should be evolved which will make it possible to contact all national associations with a view to enlisting their interest in order to deal with all phases of this most important social and public health problem.

It is suggested that in all pioneer fields when public opinion is not thoroughly aroused the value of the voluntary association is obvious. This has been proven repeatedly in various fields by various voluntary associations, recently by the Health League of Canada in the fields of nutrition, industrial health, pasteurization of milk and diphtheria prevention as well as in venereal disease.

The Voluntary Association as a Co-ordinating body

In connection with the broad educational program, therefore, every use should be made of the voluntary association, the Health League of Canada, in an effort to contact and bring into close affiliation as many national associations as possible, not only with the idea of spreading information about venereal diseases but with reference to the cooperation which may be offered by such groups as the Canadian Medical Association, the Canadian Public Health Association, religious bodies, manufacturers, women's organizations, social organizations, such as the Y.M.C.A., Knights of Columbus, Boards of Trade and a great variety of smaller groups whose cooperation would be useful.

I have also put in your hands a supplementary statement of certain odds and ends which just turned up within the last day or so. It is as follows:

SOME ADDITIONAL INFORMATION CONCERNING THE VENEREAL DISEASES IN AN EDUCATIONAL PROGRAM

The Gallup Poll in April, 1943, at the suggestion of the Health League of Canada conducted an inquiry as to whether an educational program concerning Venereal Disease was desirable. The following were the results, published on May 15th.

Would be a good idea.....	90%
Would not be a good idea.....	2%
Undecided	8%

The percentage of replies approving of an educational program is said to be the highest percentage ever reported by the Gallup Poll in favour of any project.

Report on routine blood tests (Wassermanns) on hospital patients admitted to Toronto General Hospital (with the exception of private cases) over a period of years. This test is one on patients admitted irrespective of the condition for which they are admitted. The figures are a percentage of the total admissions to the hospital per year:

	<i>Per cent</i>		<i>Per cent</i>
1916.....	10.4	1930.....	3.4
1917.....	9.95	1931.....	2.7
1918.....	5.9	1932.....	2.5
1919.....	8.8	1933.....	2.5
1920.....	9.0	1934.....	1.7
1921.....	6.3	1935.....	1.5
1922.....	6.0	1936.....	1.7
1923.....	6.2	1937.....	1.5
1924.....	5.6	1938.....	1.5
1925.....	5.8	1939.....	1.4
1926.....	4.5	1940.....	2.0
1927.....	3.8	1941.....	2.5
1928.....	3.5	1942.....	3.4
1929.....	3.2		

Report on Cases of Early Syphilis in Toronto General Hospital over a period of years:

1921	29	1932	80
1922	43	1933	73
1923	43	1934	76
1924	42	1935	54
1925	41	1936	41
1926	42	1937	41
1927	40	1938	68
1928	74	1939	103
1929	86	1940	109
1930	95	1941	131
1931	79	1942	145

Preliminary Report on a Survey done in the City of Toronto in the month of April, 1943. This survey carried on under the joint auspices of the Academy of Medicine and the Health League of Canada consisted of forwarding a questionnaire to all physicians and institutions inquiring as to the number of cases actually under treatment at a given time.

To date 913 physicians have replied to the questionnaire; 42 have not replied. Most institutions have replied.

The figures given refer only to early syphilis (new cases) and a comparison is included of figures as to a similar survey conducted in 1937.

<i>Clinics</i>			<i>Physicians</i>		
	<i>Male</i>	<i>Female</i>		<i>Male</i>	<i>Female</i>
1937	71	84	1937	149	89
1943	246	235	1943	281	173
<i>Totals</i>					
1937 Male (new cases)			220		
1937 Female (new cases)			173		
(1937) Total			393		
1943 Male (new cases)			526		
1943 Female (new cases)			408		
			934		

A statement as to occupation of women attending one clinic on May 26, 1943.

Boxmaker
Housewife
Housewife
Postal clerk
Charwoman
Housewife
Living at home
Inspector
Charwoman
Housewife
Housekeeper (hotel)
Private nurse
Cleaning—departmental store
Waitress—cafe
Housewife
Waitress—milk bar
Laundry sorter
Photo-finisher
Housewife
Marker
Munitions worker
Hostess—optometrist office
Trimmer—belts
Clerical worker—industrial plant
Salesgirl—dresses—departmental store
Bank clerk
Operator—not war work
Machine operator—war work
Clothes sorter—not war work
Assembler—not war work
Selling Cigars
Housewife
Sorting—bottle company
Housewife
Machine binder—industrial corporation
Operator—munitions plant.

Marital Status of Above

Single	12
Married	15
Separated	6
Widow	3

A STATEMENT AS TO INFORMATION GATHERED FROM AN
INSPECTION OF A FEW SOCIAL CASE SHEETS

A social history is taken in connection with each venereal case with a view to ascertaining the name and address of the source of infection as well as an understanding of the conditions under which infection takes place. A large proportion of these sources of infection were not paid.

Case 1—Met source in — — Lunch, Queen St. Went to room in — — Hotel.

Case 2—Picked up girl at — — Hotel. Went to rooming house on Dundas Street.

Case 3—Met girl at dance at — — Hotel. Went to rooming house.

Case 4—Met girl in — — Beverage room. Rented room in Hotel for time being.

Case 5—Met girl in Beverage room. Went to Hotel — —, Jarvis Street. Thinks girl came from the country.

Case 6—Met girl on party. Took her to house on Elm Street.

Case 7—Picked up girl in car. Took her to his own house.

Case 8—Picked up girl in show. Went to a room on Richmond Street. Paid 50 cents.

Case 9—Picked up girl in hotel. Went to rooming house on George Street. Says there are lots of rooming houses to which one can go.

Case 10—Picked up girl on Jarvis Street. Took her to — — Hotel.

Case 11—Picked up girl on Queen Street and went to his own room.

Case 12—Met source at a dance at the Hotel — —.

Case 13—Infected at — — Pembroke Street.

Case 14—Met girl at — — Hotel.

Case 15—Picked up girl on Church Street but too drunk to know where we went.

Case 16—Met girl in Hotel Room, Brockville.

Case 17—Girl—Goes to wherever she is taken for the night, — —, — —, — —, etc., or rooming house.

Case 18—Met girl at — — Hotel. Went to house on Sherbourne Street.

Case 19—Picked up girl at — — Hotel and got room there.

Out of 60 cases in only 10 was there direct evidence of money being paid. In 42 no money was paid. In 8 cases there was no information on this matter.

Mr. Chairman, I have summarized this brief which has been prepared to cover the matter more extensively, and that will be left with you.

The ACTING CHAIRMAN: The brief will go on the record in full. Is there any interrogation of Dr. Bates?

By Mr. McCann:

Q. Connecting up the submission by Dr. Bates with reference to the social security program, and more particularly the matter of health insurance, may I ask if Dr. Bates is of the opinion that, if a plan of health insurance were put into effect, these conditions which he outlined would be greatly ameliorated and that the objectives which he has in view would be met to a greater extent than they are at the present time? Another question I wish to ask is this. In the event of health insurance going into effect, what will be the position of voluntary agencies? Will they go out of commission or will there be more work for them to do under a health insurance scheme than there is at the present time?—A. Mr. Chairman, I am sorry that the minister has left, because I should like to have been able to answer that question when he was here. As you know, Dr. McCann, the voluntary committee have felt for a great many years that the important thing with reference to health in this country should be that there shall be dominion leadership; that is, that health shall be considered as a definite national objective. For the first time there is evidence in this house of the question of health being taken seriously. My feeling is that if there is a definite national health program of the kind outlined by Dr. Heagerty, all of these things working together will certainly help us to control venereal disease.

On the question of voluntary associations, my feeling is that as there are so many things still to be done, the position of the voluntary association, with the sympathy which has developed in the dominion, should be stronger. Take, for example—to get off the question of venereal disease—the question of the pasteurization of milk, about which I have had a great many arguments with my friend Mr. MacInnis. Pasteurization of milk by public health authorities is considered to be an essential. But it cannot become effective without popular opinion. In the province of Quebec at the present time a vigorous campaign

is being carried on by a branch of this voluntary association, with the object of calling to the attention not only of the legislators but of all societies the fact that such a law must be passed; and I believe, from all that I can see, that if that law does not go on the statute books this year, it will be on next year. I do not know any other way in which such objectives may be achieved. Popular opinion must be aroused; but it must be aroused not by the governments, who find that sort of thing impossible, but by the people outside of the government, with the sympathy of the governments. I do not know whether that answers the question completely; but the same thing applies to such a thing as periodic health examination, for example. We have not done very much about that. It is going to take education to get that done. The same thing applies to diphtheria. There are many areas of Canada in which diphtheria control is still not anything like what it should be.

Q. Are you of the opinion that the educational program in health lines should emanate from the central or federal authority rather than from the provincial authority?—A. I think we have got to think as Canadians, not as Nova Scotians, Quebeckers or Ontarians. I have always felt that way.

Q. The problems are very similar from one end of the country to the other?—A. Yes. The problems are very similar from one end to the other. There should be co-ordination in the development of a national spirit. I should like to see a national health statute such as they have in New Zealand, which has the lowest death rate in the world.

By Mr. Slaght:

Q. You referred to the fact, as I understood you, that in some of the states of the union there is existing legislation making examination before marriage compulsory. Do you happen to have, in pamphlet or other convenient form, or could you file with our secretary any of the particular statutes prevailing in the different states? We could dig them out by going to the library, of course. But if you have them collected and could make them available to our secretary, without going into them now, it might assist those of us who thought that legislation of that character should be drafted to be submitted here.—A. Such legislation, Mr. Slaght, exists in thirty-two states of the union. That legislation has been collected and is readily available.

By Mrs. Casselman:

Q. I think it was Colonel Williams who said that there is already quite a bit of legislation on the provincial statute books but it had not been put into effect. I wonder if we could be told just why it had not been put into effect. Would it be because there was not sufficient financial backing? Or would it be because there are not enough doctors? Or would it be because the desire to put into effect was not there or the idea of compulsion was not sufficiently strong? I wonder if we could have an answer on that point.—A. There is now on the statute books of each of the nine provinces reasonably effective legislation. Our experience has been that the existence of this legislation, particularly the phase which has to do with compulsory treatment, has made a great difference in the effective treatment of the disease, particularly by clinics. Then, the fact that a person can be compelled to take treatment is a very powerful factor when it comes to efficient action. I think what you refer to is the failure of physicians to report. That is a fact. I do not know whether or not Dr. Williams has any cure, or whether Dr. Heagerty has any cure for the situation. But it is true that physicians do not report, and I do not know how to make them.

Mr. MAYHEW: Mr. Chairman, what I am going to say is somewhat personal, and I do not know that it is necessary for it to go on the record. At the same time it is an experience that will probably help those who are dealing

with this matter. A few years ago I felt that we had a certain responsibility in connection with our own employees in this matter. We called in our shop committee and suggested to them that we would have a medical examination made of every man in our industry, and so long as they would agree that every one would be compelled to submit himself to medical examination, we were prepared to pay for it. The committee came back and reported that they were satisfied to go ahead. I mention that to show that labour is willing to go all the way with you. The promise made to them was that there would be nothing said about anything the matter with them physically unless it was social disease, in which case each case would be examined by itself. We conducted that annually, and in 1940—that was the first year of the war—so far as our place was concerned, it was 100 per cent without the disease. They were submitted to the Wassermann test. I thought that would be valuable information and be encouraging to you as an example of how it could be weeded out in industry. If those engaged in industry, will take that interest in their own employees, I am satisfied that inside of three years' time they can weed it out. What can happen in industry can happen in any other activity—departmental stores, hotels or whatever you like. Of course, in some industries the turnover is greater than in others, and it is harder to control. Since the war the turnover in all businesses is so great that I would not like to say you would get the same results at the present time even in our own group of people.

The ACTING CHAIRMAN: There is no reason why that should not go on the record unless you wish to have it withheld.

The WITNESS: Mr. Chairman, may I say a word as to that. I took the opportunity yesterday of sending each member of this committee a copy of an industrial health program designed for industry. That has to do with health in general. One of the essentials of that scheme is pre-employment and periodic health examination of all employees. That will, of course, include the Wassermann reaction. If industry will take an interest in the general health of the employees, it provides an excellent opportunity to put on the form used for medical examination the Wassermann reaction; and that is already being done in some of the large war industries.

By The Acting Chairman:

Q. Industry generally is now swinging that way, is it?—A. Very much.

Mr. McCANN: I was going to ask Dr. Williams a question. I presume that the incidence of venereal disease is very definitely on the increase where there are large concentrations of troops. That is the experience in most countries. I was reading a very interesting article in the Reader's Digest of this month, I think it was, with reference to the means that are being taken by the public health authorities down in a place called Leasville, Alabama, in rounding up the contacts and putting them under treatment. Could Dr. Williams, in view of his position both with the army and with the Department of Pensions and National Health, state whether or not any such plan as that is necessary; and if necessary, is it contemplated in this country?

The ACTING CHAIRMAN: Dr. Williams, would you reply to that question?

Lt.-Col. WILLIAMS: Dr. McCann, this is a most important question and has great practical implications as far as the army is concerned. The men who acquire venereal disease in the armed forces are wounded with it as casualties in the adjacent civilian community. It does not necessarily follow, and it does not actually happen to be so, that in Canada, where the greatest concentrations of troops are situated, the rate is highest. As a matter of fact, in one community, where one of the heaviest concentrations of the armed forces is, it has the lowest rate by far.

Mr. McCANN: That would be because it is pretty well isolated; is that it?

Lt.-Col. WILLIAMS: This is not an isolated community at all, but it is a community that for five years has been spending three times as much money per capita on V. D. as any other community. It is a community that has been cleaning up disorderly houses, red-light districts, taverns and so on. The incidence of infection among the armed forces in Canada is directly proportionate to the action of the civilian community authorities against the facilitation process.

Mr. McCANN: What is the incidence in places like Halifax where they have not been as progressive?

Lt.-Col. WILLIAMS: It is considerably higher than, let us say, the average.

Mr. McCANN: Then what about the other part of my question? Is any attempt being made to take those who are contacts, segregate them and give them treatment? Or is there just an attempt to shew them out of that particular district into some other district?

Lt.-Col. WILLIAMS: A very comprehensive program, which will be implemented not later than July 1st and is about half-way under at present, has been arranged whereby every man in the armed forces who acquires an infection will be queried on two specific bases. First, he will be questioned regarding the civilian contact that wounded him with venereal disease. That information will be assiduously collected from the men and sent to the civilian health department. We will also collect information on the other basis, the facilitation process—what were the community conditions and who were the third parties who were associated with making it easy for that healthy, robust man from a good home in Canada, to reach this highly infected contact. That information will be collected carefully and it will be passed, not to the health department but to the proper law enforcement and licensing by-law authorities in the community concerned, putting the responsibility on their shoulders.

Mr. McCANN: To follow up that, may I say that in my judgment there is where the great difficulty will lie. Will that community take hold of that problem? Or, in view of the war conditions and the war emergency, should not that be a problem which would be taken up by the federal authorities, and the proper treatment follow?

Lt.-Col. WILLIAMS: The deputy ministers' meeting at the Dominion Council of Health a month ago asked that special federal legislation be implemented under the War Measures Act to put teeth into it.

The ACTING CHAIRMAN: I am afraid we have used up our time limit. I should like to express on behalf of the committee very warm thanks to the ladies and gentlemen who have appeared before us this morning.

I understand that the meeting will be adjourned until Tuesday, June 1, when we shall hear the Christian Scientists and the optometrists.

The Committee adjourned at 1 o'clock to meet on Tuesday, June 1, at 11 o'clock a.m.

APPENDIX "A"

CANADA'S NATIONAL HEALTH AND VENEREAL DISEASE CONTROL

A BRIEF ON THE GENERAL POLICY CONCERNING CANADA'S NATIONAL VENEREAL DISEASE CONTROL PROGRAM

D. H. WILLIAMS, Lieut.-Col. R.C.A.M.C.

Army Venereal Disease Control Officer Department of National Defence and
Chief, Division of Venereal Disease Control Department of Pensions
and National Health and Director, Division of Venereal Disease
Control Provincial Board of Health, British Columbia

Presented to: Special Committee on Social Security.

In the entire realm of national health no single problem looms quite as large, nor is currently so important as that of venereal disease. Unlike most of our national medical problems its root lie buried deeply in inherent defects of human behaviour; in remediable unwholesome community conditions; and in a failure to apply effectively the measures of modern medical science. No people are in a better position to overcome the threat of venereal disease than are Canadians to-day. The will to banish this "fifth column" from our midst must encompass a concerted attack. With the home and church lie the responsibility for strengthening the bonds of family life and fortifying individual character. On citizens generally, and on civilian authorities particularly, rests the onus for remedying unwholesome community conditions which predispose to the spread of venereal infection. Those entrusted with the armaments of public health must use them adroitly and aggressively.

The easily preventable human tragedy of syphilis and gonorrhoea is largely a heritage of neglect, prudery and a failure to face squarely the problem and its causal background. What other countries have done Canada can do. Great Britain in twenty years cut its syphilis rate in half. In twenty years the Scandinavian countries conquered syphilis and reduced it to the status of a rare disease. For over thirty years modern medical science has been extending for Canada to use the weapons necessary to destroy the venereal diseases. During all this time painstaking research has steadily improved these armaments. These public health weapons are still largely unused.

We do not have to look to Europe to see the national dividends accruing from comprehensive venereal disease control measures. In the United States the courageous programme launched by the United States public health service under the forthright leadership of Surgeon-General Parran, endorsed and supported by the people of the United States and their governing agencies has reduced venereal disease in their Armed Forces to unprecedented low rates. Large sums of federal money have been made available to local health departments and guidance has been given in the wise expenditure of this money. A special government agency, the Social Protection Division, has been set up, whose sole purpose is to lead the attack against illegally operating, disease-dispensing, disorderly houses and other unsavory community influences. In the words of Surgeon-General Parran—"The cheapest thing we can do with syphilis is to cure it."

Reduction of venereal disease in countries that have had the satisfaction to experience this favourable trend, has gone hand in hand with public enlightenment and education; with general recognition of social and economic factors as

profoundly influencing the prevalence; with a national morality envisaging homes where warmth, food, security and affection abound; with a high regard for justice and the enforcement of laws directed against the third party participants in commercialized prostitution.

Canada's response to the challenge is a four sector Canadian front against venereal disease. The sectors, which united, co-ordinated and welded into an impregnable line will advance upon syphilis and gonorrhoea are the health, welfare, legal and moral sectors—components of an indivisible whole aligned against a common foe. The ultimate objective is to destroy syphilis and gonorrhoea. The purpose of each sector is to take the offensive on its own sector with the weapons peculiar to its own particular method of attack. Waging unrelenting war on the health sector with the weapons of modern medical science and public health procedure will be found physicians, nurses, health departments, university medical training centres and hospitals. Leading the attack on the welfare sector will be social workers and welfare agencies armed to battle squalor, over-crowding, inanition, neglect and insecurity. Directing a vigorous, unrelenting, sustained action on the legal sector are the courts, the legal profession and police agencies, whose action seeks out and brings to justice those who for personal gain purvey to men's weaknesses. On the moral sector the battle is lead by the churches and homes of Canada, strengthening the moral fibre of our nation, inculcating the moral wisdom of the ages and upholding the sanctity of marriage and family life.

Each sector is well defined from the standpoint of its territory, its personnel and its armaments. The ultimate objective is the same. Each must respect the part which the other plays in the engagement. Each must recognize its sector as integrated into the Canadian four sector front against venereal disease.

The health sector forces are being marshalled! Strategy is being revised and reorganized with a view to intensifying and coordinating all preventive control health measures, keeping always in mind the necessity of correlating closely health action with welfare, legal and moral action. It is anticipated that a common strategy will be adopted by all health agencies throughout Canada. Toward this end the departments of national defence jointly with the Department of Pensions and National Health and the provincial health departments are working in close cooperation.

The basis of the six point strategy on the health sector rests upon the axioms that syphilis and gonorrhoea in common with other communicable diseases are vulnerable to the weapons of public health and thereby may be cured and prevented. Canada has reduced smallpox, typhoid fever and diphtheria to the status of rare diseases; tuberculosis is being overcome; venereal disease is the next great plague to go! The backbone of the health sector lies in the facts that cannot be reiterated too often and too loudly—syphilis and gonorrhoea are curable and preventable! The word "curable" is the artillery, the word "preventable" the infantry of the health thrust. They will carry the battle deep into enemy territory. They will rip wide open the enemies' defences.

The first of the six points equal in the health strategy is public education. Public enlightenment on a wholesome, dignified, reasonable basis will silence false fears, banish outworn fallacies and end the tragic conspiracy of silence in which we have all been partners. Today, fortunately, there is a wide-spread desire on the part of citizens for factual information concerning syphilis and gonorrhoea. Fear and defeatism are giving place to frank, intelligent discussion of this major Canadian health problem. To encourage this wholesome trend a vigorous health educational programme is under way which will bring the facts to our people. The informative material and the media are to be carefully selected. The content will be designed to support and not jeopardize in any way the program of the welfare, legal and moral sectors.

Adequate diagnostic and treatment facilities for everyone in Canada is the second point in our health strategy. It is our duty to see that every Canadian who requires examination or treatment shall have the best that modern medical science can provide. Today, provincial health department laboratories heavily weighted with extra burdens thrust on them by the war are providing in spite of shortages of staff and equipment a heroic service to the nation. They must be assisted if they are to carry on and meet the ever-increasing demands for their service. With public recognition of the need to discover and treat the hidden syphilis in our midst, there will be even greater demands on their facilities. Each year the federal government carries the war against syphilis into every corner of the country by purchasing and distributing through the provincial health departments \$50,000 worth of arsenicals to private physicians, hospitals and clinics.

There is no place in Canada today for the treatment of venereal disease by unqualified persons using fraudulent and dangerous procedures. This is the basis of the third strategic point. Quackery and charlatanry must go. The natural prejudice, fear and prudery associated with syphilis and gonorrhoea have played into the hands of rogues who pose as specialist in treating "blood diseases" and the "ills of men". These vultures take from the infected victim not only his money, but also his chances of being cured. Precious time is lost. The infection is only aggravated and perpetuated. Adequate provincial laws exist to meet this danger to the national health but are not being enforced.

The fourth point in the health sector thrust focuses upon the greatest of all tragedies in the realm of syphilis—the innocent infection of little children, little children who through no fault of their own come into this world bearing the cross of a body honeycombed with syphilis. This continuing, preventable, pathetic blot on our national health could be erased within one year by a simple expedient—adequate medical prenatal care of the expectant mother before the fifth month. It is now known that if syphilis in an expectant mother is discovered before the fifth month by blood testing and if proper weekly injection treatment is instituted, the new born baby is given almost a hundred per cent chance of being normal, healthy and completely free from syphilis. This fact must be known to every woman in Canada. If every expectant mother in Canada went to her physician before the fifth month and if every physician in Canada were to take a blood test for syphilis and provide proper care where necessary, syphilitic babies before this year is out would become a rarity in our land.

Another tragedy inseparably bound with the foregoing and antedating it, provides the reason for our fifth point. This is the innocent infection of young Canadian wives following marriage. A prime requisite to the establishment of a sound home is sound health on the part of the husband and wife—the future father and mother. Wise partners preparing for marriage recognize that successful family life is contingent among other factors upon health and physical fitness. Syphilis discovered in an unsuspecting partner can be treated and cured by careful medical examination and blood tests. Thereafter a home with children can be established without danger or ill effect.

The sixth and final point in the health sector of the front against venereal disease involves effective measures directed toward seeking out and treating those persons who are wittingly or unwittingly spreading infection and closely related thereto and equally important measures to deal with the facilitators directly and indirectly associated with unsavory community conditions which make it easy for highly diseased persons to spread their infection. Reference is made particularly to houses of prostitution and other less obvious places of facilitation. This problem is best outlined in the words of Dr. Walter Clarke, executive director of the American Social Hygiene Association, in urging that people be educated to the problems created by prostitution: "They must feel sure that prostitution cannot be made safe and sanitary; that it spreads disease; that it corrupts the

morals of young people; breaks up families; demoralizes public officials; provides a haven for petty criminals; and is constantly associated with inebriety and drug addiction. In short, if citizens are sure that there is nothing good about prostitution and that it is entirely undesirable, they will favour its repression, both during and after the war."

To summarize, these are the salient features of the six point plan of strategy that the health sector has adopted:—

1. Wholesome, dignified health education concerning syphilis and gonorrhoea.
2. Adequate diagnostic and treatment facilities for all persons suffering from venereal disease.
3. The suppression of quackery and charlatanry in the treatment of venereal disease.
4. Early adequate prenatal care including blood tests for expectant mothers to prevent the tragic innocent infection of babies.
5. General health examination including blood tests for syphilis on a voluntary basis before marriage.
6. Effective measures to deal with persons and community conditions associated with the deliberate spreading of venereal disease.

The greatest assurance that the problem of venereal disease presently being recognized in its true light as a major national health problem, will continue to receive the serious attention it merits would be the incorporation of means to adequately deal with it as an integral part of a national health insurance program.

What the exigencies of war have initiated it is hoped the well thought-out plans of peace will maintain and sustain till that fortunate moment for Canada, its people and its homes has been reached when they may look back and see syphilis and gonorrhoea added to the lengthening list of vanquished foes of their health and happiness.

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SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 16

TUESDAY, JUNE 1, 1943

WITNESSES:

Mr. J. W. Fulton, Christian Scientists of Canada;
Mr. A. W. Eckman, Christian Scientists of Canada;
Mr. Geo. B. Bagwell, Optometry Board of Examiners;
Mr. H. S. McClung, President, Canadian Association of Optometrists;
Mr. J. H. Lionel Hebert, Canadian Association of Optometrists;
Mr. Edward Bind, Secretary, Canadian Board of Optometrists;
Mr. Frank Fisher, Ontario College of Optometrists.

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1943



MINUTES OF PROCEEDINGS

TUESDAY, June 1, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs.: Adamson, Blanchette, Bourget, Casselman (*Mrs.*) (*Edmonton East*), Cleaver, Coté, Diefenbaker, Donnelly, Fulford, Gershaw, Gregory, Hatfield, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, Slaughter and Warren.—24.

Mr. Roebuck, M.P., introduced the following delegates of the Christian Scientists in Canada:—

Mr. J. W. Fulton, foreman of the Committee on Publications;

Mr. A. W. Eckman, Boston, Mass., foreman of Committee on Publications in America;

Mr. Harry Southam, Ottawa;

Mr. Fulton was called, presented a brief, was examined by the Committee and retired.

Mr. Eckman was called, examined and retired.

By leave of the Committee Mr. Hansell, M.P. examined the last named witness.

The Chairman thanked the witnesses for the submission of their evidence.

Mr. Roebuck, M.P. introduced the representatives of the Optometry Board of Examiners: Mr. Geo. B. Bagwell, Col. Cooper and Mr. Frank Fisher.

Mr. Bagwell presented a brief, was examined and retired.

Mr. H. S. McClung, President of the Canadian Association of Optometrists was called, presented a brief, was examined and retired.

Mr. J. H. Lionel Hebert, also representing the Canadian Association of Optometrists, was called, presented a brief, was examined and retired.

Mr. Edward Bind, Secretary of the Canadian Association of Optometrists, was called, examined and retired.

Mr. Frank Fisher, Ontario College of Optometrists, was called, examined and retired.

The following delegates were also in attendance:—

Mr. W. J. Maxwell, Secretary, New Brunswick Optometry Association;

Mr. F. Nuttall, Secretary Treasurer, Alberta Optometry Association;

Mr. D. A. McGuire, Manitoba Association of Optometry;

Mr. A. Mignot, Vice-President of Canadian Optometry Association, and President of the College of Optometrists; and

Mr. J. G. Fogo, representing the Board of Examiners of Nova Scotia.

The Committee adjourned at 1.25 p.m. to meet again Friday, June 4th, at 11.00 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS, June 1st, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock a.m. The Chairman, the Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Order, please.

Mr. ROEBUCK: Mr. Chairman—

The CHAIRMAN: We shall hear this morning from the representatives of the Christian Scientists, Mr. J. W. Fulton.

Mr. ROEBUCK: That is all right; I think now I have the right to say, "Mr. Chairman", at least.

The CHAIRMAN: Certainly.

Mr. ROEBUCK: Mr. Fulton has a number of copies of his brief—

The CHAIRMAN: They will be distributed by the secretary.

Mr. ROEBUCK: And I would like to see them distributed.

The CHAIRMAN: Yes.

Mr. ROEBUCK: I would like to point out to the committee that Mr. Fulton is the foreman of the Committee on Publications, which is the Public Relations Officer of the church; and that we have here with us Mr. Eckman, of the committees on publication, from Boston, representative of all the churches in America; Mr. Harry Southam, whom we all know, from Ottawa; and Mr. Van der Voort, President of the Committee on Publications. They form the delegation, and Mr. Fulton will speak on behalf of the delegation; and I now have pleasure in introducing to you Mr. Fulton.

Mr. J. W. FULTON, called.

Mr. ROEBUCK: I think there is another thing I ought to say, Mr. Chairman; it has been arranged among the three delegations who have come here—that is, the Christian Science delegation, the Board of Optometry and the Optometry Association—to divide up the two hours which is available, by arrangement amongst us. The Christian Science representative will speak for one hour and twenty minutes, the Board of Optometry for twenty minutes, and the balance of the time which is twenty-five minutes will be used by the Optometry Association. Nobody will overrun his time.

The CHAIRMAN: We will proceed with Mr. Fulton.

The WITNESS: Mr. Chairman, Mrs. Casselman (if she is present)—

The CHAIRMAN: She is not yet.

The WITNESS: —And gentlemen: We want first to express appreciation to the Hon. Ian Mackenzie and the Advisory Committee under the chairmanship of Dr. Heagerty for the democratic approach to this important subject and for asking us to present our case. I think that augers well for the future of the act that there is an effort being made to understand the effects of the various groups who are interested; that position is better than placing the power arbitrarily in the hands of a central committee, because civilians do not react very favourably to such a policy. And now, before going into a consideration of the bill itself I feel it is only fair that I should give you gentlemen a brief, introduction, at least, to the teachings of Christian Science, so that you may understand the relationship which exists between our religion and the legislation which is being proposed.

Christian Science is a religion based on the teachings of Christ Jesus, and it is also a healing system. It is vital for us to remember that it was the healing power exercised by Christ Jesus in the healing of sickness and sin which gave vitality to his ministration for the masses. Had healing been left out of his work then perhaps his ministrations, or his ministry, would not have had any more power to waken up humanity, than would moonbeams have to melt a river of ice. He did not claim that only for himself; but he and his disciples; they in turn taught for themselves; and so the early Christians were healers. This is a point supported not only by Biblical but also by secular history; and Gibbons in his *Decline and Fall of the Roman Empire* speaking of the work of the Christian church refers to this healing of unfettered disease goes on to say: at the time of the Emperor Auranius, about the end of the second century, the raising of the dead was by no means an uncommon event. Unfortunately the Dark Ages descended and this healing power was temporarily obscured. But thank goodness the Christian churches throughout the world to-day are trying in a measure at least to recapture some of that vital power. It is interesting to note that many of the leaders of the prominent religious groups practise healing by prayer, thank God, to a very great extent. Luther healed his co-worker Melauchthon by prayer when the latter was at the point of death. The biography of John Wesley records many salvations by prayer. And so we can be grateful for any contribution which has been made by any church in that way that is pertinent to the recapture of this vital power of the ministry of our Master.

And now, Christian Scientists rejoice in anyone turning to prayer, whether it be a minister or a priest at the bedside of the sick, or it be a doctor who in the privacy of his home or office turns reverently to God in prayer. We do not claim any monopoly or any exclusive rights. We claim for ourselves and for all people the inviolable right of healing by prayer; that is an inherent right of man.

And now, that electrical genius, Steinmetz, who was in charge of the research work of the General Electric company in Schenectady, New York, made the statement some few years ago which has a very direct bearing—if I may quote it verbatim:—

He said, the greatest discoveries of the next half century will be made along spiritual lines. Here is contained that force which history clearly teaches has been the greatest power in the development of man and history; yet, we have been merely playing with it and have never studied it as we have material forces.

And now, there is a man who knew well the latent powers of so many things; and Steinmetz when asked where the greatest discoveries would be made he turned to spiritual power. Now, Steinmetz was pointing in the right direction, but we will admit that he was pushing aside that which the Bible refers to as, food that is good for all people; but Steinmetz was not a Christian Scientist, or perhaps he would have been able to recognize that considerable progress had been made in understanding and exercising this great vital power.

And now, as Christian Scientists, in fairness may we say that there is virtually very little difference between Christians on the great subject of prayer. When an individual comes to Christian Science he begins at once to learn the very close and intimate relationship that exists between God and man. He begins to learn that God is indeed his Father; that the Father's will for his beloved son is infinitely good. Then, as he studies the nature of God he begins to understand that God is life, truth and love. Then he begins to awaken to the fact that his Father who is divine-love could have for us, logically and scientifi-

cally, only that which is loving and lovable; and that because God is life that he can bestow on his beloved son only that which is conducive to living, health, strength and freedom.

And now, you may notice that there is a difference in approach here. We do not beg God to do something, nor ask him to change his plan; because we feel that God was the same yesterday, to-day and forever; and because he is life and love his power offereth nothing but good to his creation. Instead of asking him to change—and, by the way, we do not think we have enough intelligence to tell him to change—instead we change ourselves; we try to bring every thought, motive and act, so much into harmony with God and his great plan and purposes for men that the benefits and blessings of that divine love, and the health and healing of the divine life, finds expression in our individual experiences.

And now then, that that produces individual results can be established by irrefutable proof. It is found in better bodies, happier faces and so forth; and, also, many of these have been placed down in writing on paper. Some of these—a few, a small percentage, have appeared in the *Christian Science Sentinel*, or *Journal*. And now, referring to this for just a moment, just within this last month, the month of May—may I inform you that the greatest human care is taken to ensure that every statement that appears in this publication is accurate; every testimony must be accompanied by at least a statement, a verification of three individuals who are acquainted with the facts; or, by sworn affidavit. And now then, I might just mention a few of these healings: one was the case of an infant; due to some prenatal condition—one of twins—there was a deformity; and they called in three doctors altogether—the child was at the age of about ten months—and they said that she would always walk with her head and shoulders thrown away back and one leg would likely be shorter than the other. Shortly after they had given their verdict a Christian Science teacher was asked for—I say this with all respect to the doctors; we are dealing with a different system and possibly get different results. We are dealing with the spiritual, where they in turn are dealing with the material, and we have all respect for the material—with the result that at the age of sixteen months the child was walking normally, and at three years she was perfectly well. Now, there was the case of an internal condition with a woman; now, seven doctors and three specialists had said that that condition could not be rectified without a major surgical operation. She was healed in Christian Science. Then you have the case of a clergyman's wife who had a certain condition such that she was told that approaching childbirth would prove fatal. She was completely freed of this condition through Christian Science, that included a thyroid condition—goitre, and as well Adamson's disease. Another case was that of peritonitis in the bowels, a condition which the doctors stated could not be relieved without the patient being operated on through the side with a knife. And now, three days after Christian Science teaching was started, the bowel began to function and returned to normal conditions. I could go on; but I want to say on this point, and I say it with thought, that while we disagree radically with the system of administering medicine to the body, nevertheless we have the highest and greatest respect for the unselfish noble life motives of these fine gentlemen, the doctors of medicine; and I would like to go on record as saying that. So, while we have disagreement as to the use of the remedy, we have that respect and we wish it to be retained.

And now then, with that preface, perhaps I may be privileged to turn directly to our brief; and you will pardon me if I stay fairly closely to my script, for the simple reason that today on the road that we are travelling there are so many beautiful scenic detours that we may get lost and not arrive at our destination at the time which has been announced by Mr. Roebuck.

It is on the grounds of religious freedom that we ask your honourable committee to exempt Christian Scientists from contributing to the maintenance and sharing in the benefits of the proposed dominion-wide national compulsory health insurance plan.

Such an exemption will in no manner interfere with the functioning of the plan. It will not hamper the work of the medical practitioners, nor will it place any obstacle in the way of those citizens who desire to avail themselves of medical aid through the state. It will not relieve Christian Scientists of their obligation to obey sanitary rules and regulations—an obligation which they have always meticulously discharged. At the same time, this exemption will further strengthen the recognition of religious freedom—one of the principles on which our government rests—and so will avoid the injustice of taxing some citizens of the dominion for a form of treatment contrary to their religious principles and which, in consequence, they cannot accept.

Should you grant our request, you will be following a precedent set some years ago by one of the provinces. In fact, the language of the model amendment we ask you to insert in the draft dominion bill is substantially the same as that to be found in Part 1, clause 4 of the British Columbia Health Insurance Act of 1936.

Should you grant our request for exemption, you will be acting in harmony with the long-established policy followed, not only by Canada, but also by all the other members of the British Commonwealth of Nations, wherein freedom of religion, like freedom of speech and freedom of assembly, is no mere privilege to be granted or denied by a government, but is a manner of life so sincerely believed in and so consistently recognized as to warrant identification as a constitutional right.

Christian Scientists favour any legislation which will permanently improve human relations. Not only do we not oppose a Canadian social security program; we favour it in its broad objectives. We appreciate the human need and realize that many human efforts to achieve security must be experimental. Perhaps, no matter how desirable they may appear, some endeavours will turn out to be too costly, hence uneconomic. Yet our concern, as a church, is not with debatable economics; it is with undebatable religious principles.

It is because we have a sympathetic understanding of the problem that we are eager to help and not to hinder you in attaining the end you seek which is the ultimate emancipation of mankind from "fear and want," to quote the words found in the Atlantic Charter. We would go even further, and look forward to that time when every individual can realize his complete freedom and inviolable security as a son of God.

To insure its success, a lasting social security program not only should refrain from that which is palpably unjust; it really must make certain that that which is wholly just is authorized and practically operative.

While, during the fifty years and more of its existence in Canada, Christian Science has not grown to a place among the largest denominations, neither is it now by any means among the smallest. There are seventy-six branches of The Mother Church, The First Church of Christ, Scientist, in Boston, Massachusetts, distributed throughout Canada.

I may add there are in the neighbourhood of 2,700 Christian Science churches throughout the world and in excess of 10,000 Christian Science practitioners, individuals who devote their life exclusively to the healing of the sick and have no other interest, commercial or otherwise.

Although they have some thousands of members, their attendants and friends run into considerably greater numbers, while it is justifiable to say that those who, to a degree, share our religious viewpoint, may well approxi-

mate a majority of the Christian believers in the dominion. This religious viewpoint is the acknowledgment that God is not only able but ready to care for His own. That Christian Scientists go further than do other denominations and claim for all men the right to avail themselves of God's power to heal from sickness and to save from sin is no reflection upon these other denominations, nor is it reason for anyone to regard us as peculiar people.

DRAFT BILL IN HEALTH INSURANCE

It will be unnecessary for me to refer in any detail to the great bulk of the evidence in relation to social security which has been laid before this committee. We take it that the pith of the subject matter for the committee's consideration is to be found in the draft bill which has been submitted to you by the officials of the Department of Pensions and National Health, the sub title of which is

An Act respecting Health Insurance, Public Health, The Conservation of Health, The Prevention of Disease and other matters related thereto.

This is an official proposal, most sweeping in character, and were it enacted by parliament would be of great national importance. We purpose confining our remarks in the main to these features of the suggested enactment which are restrictive of religious liberty and repugnant to the tenets of the Christian Science Church.

The bill is not, however, objectionable in toto from our point of view. Christian Scientists both individually and as an organization give most willing support to all sanitary measures enacted for the protection of the community, and we carefully observe the laws and regulations with respect to contagious and communicable diseases. We do not favour, however, measures which encourage people to rely upon *materia medica*, rather than upon divine protection, and we strongly oppose compulsory inoculations and vaccination as a violation of personal freedom, though we would not deny them to those who actually desire them.

There are certain services which are made useful by the members of our church, the cost of which might possibly be met in advance by periodical payments, but the insurance plan before the Committee involves such entanglements with systems of material healing, such infringements of personal and religious freedom, and is generally so contrary to the practice of our religion that we will be much better off, and the operation of the Act will be much simpler, if you will allow us to remain as we are; and while Christian Scientists may make use of dentistry and obstetrics and other such services and occasionally of nursing and hospitalization, they prefer to pay these costs as they occur, and they do not favour as applied to themselves compulsory contributions to an insurance fund for this purpose.

While disclaiming any intention of destroying the bill as a whole, we submit that it has features which are highly objectionable and which are not necessary or essential to its main purpose. We oppose the measure as it now stands.

First, as citizens because, as we understand it, the bill will result in undue and objectionable interferences with personal freedom.

Second, because the Bill is designed to create a monopoly in the healing arts, and

Third, as Christian Scientists because it would compel us to take part in a system which is contrary to the religion which we profess.

We have been assisted to an understanding of the proposed Bill by the official summary which appears at page 3 of the volume entitled:

Health Insurance, Report of the Advisory Committee on Health Insurance appointed by Order in Council P.C. 836, dated February the 5th, 1942.

BILL IS CONTRIBUTORY AND COMPULSORY

From this summary we learn that the proposed health insurance measure is to be contributory and compulsory and, subject to consent of the respective provinces in which they reside, is to include all persons resident in Canada. It is contributory to the extent that all who can pay, either as employees or property owners, must pay, and it is compulsory in that no avenue of escape is afforded to those who do not desire to share in its supposed benefits, or who for some other reason do not wish to be a part of the system. I quote from paragraph 7 of the summary as follows:

Registration—As soon as health insurance is adopted in a province, all residents will be registered and classified and will be instructed to select a doctor from a list provided after consultation between the Provincial Health Insurance Commission and authorized medical body.

May I pause here, Mr. Chairman, to point out to you what is already fairly well known in Canada, that the members and adherents of the Christian Science Churches of Canada do not feel themselves in need of the general services of a medical doctor, and that they will strongly object to and strenuously oppose being "instructed" to select one, though his name appears on a list however provided. The summary says that all residents are to be "registered and classified". The members and adherents of the Christian Science Churches do not wish to be so regimented for such a purpose.

I quote from the last few lines of paragraph 8 of the summary:

Thus, the physician would have a responsibility for the health of each member of the family and he would be responsible for public health measures designed to reduce morbidity and mortality. He would act as counsellor, advisor and supervisor in respect of the health of the whole family as a unit.

In the past, the family has been considered the basic unit of civilized society, and all assaults upon its integrity have been strongly resisted. Apparently this idea is now to be discarded and the individuals of the family are to become members of a semi-military health company, of which the doctor is to be sergeant-major. The counsel and advice which he has given so generously in the past, to be accepted or rejected in freedom, is now to be invested with the majesty of the law. There is a peculiar significance in the word "supervisor". It carries with it the suggestion of the overseer, the taskmaster, and possibly the rod of the schoolmaster, or should I use a term a little stronger than "schoolmaster?" If I may just add something here I noticed just in passing in the minutes of the committee on page 55, something which appears in the testimony or remarks of Dr. Heagerty:—

In many countries they give only the doctor and the drug. That is not sufficient. The individual must have a doctor; he must have his general practitioner.

I do not know how we are going to define this word "must". It does not leave much alternative.

The individual must have a doctor; he must have his general practitioner.

Then the next one is the hub of the subject.

The individual must place himself and his children in the hands of that practitioner, and that practitioner must have the privilege of calling in the consultant and the specialist and the surgeon and sending the ill individual to hospital, and that individual must receive all the hospitalization that is necessary.

I do not want to be unfair. I could interpret that word "must" as meaning that we must accept. Perhaps our good friend, Dr. Heagerty—I trust he will not object to my calling him "good friend"—has the idea that the government must provide services; but the Bill is not clear on the point exactly. I looked all the way through these minutes to see if any member of the committee had raised objection to that strong word "must" in these various connections, and I found no voice raised in objection. I will proceed.

Frankly, gentlemen, we do not relish the thought of being regimented by the state for the purpose of being supervised by a medical superior in matters so intimately personal as our own or our family's health.

May I now turn to the Bill itself, and direct your attention to section 28, s.s. (2), which reads as follows:—

(2) The regulations and arrangements aforesaid shall be such as to secure that qualified persons shall, subject to the provisions of this Act, receive from medical practitioners with whom arrangements are so made all such adequate measures for the prevention of disease and all such proper, necessary and adequate medical, surgical and obstetrical treatment, attendance and advice, as may be prescribed, and the said regulations and arrangements shall, subject to such terms and limitations as may be included therein, be such as to secure:—

(e) The distribution among the several medical practitioners whose names are on the list, so far as practicable under the arrangements made by them, of qualified persons who after due notice have failed to make any selection or who may have been refused by the medical practitioner whom they have selected.

Apparently it is intended that all "qualified persons" shall receive from medical practitioners preventive measures and medical services as may be prescribed by the medical practitioners whether they like it or not, and irrespective of how earnestly they may object to the intended benefit. Have we not yet learned the futility and inadvisability of attempting to enforce upon others what may appear to us as benefits but which to them is objectionable. The glimpse which s.s. (e) of Section 28 gives of the managers of this proposed medical system dividing up among the medical practitioners those conscientious objectors, who after due notice have failed to select their medical supervisor, is not a pleasant spectacle.

For what purposes are these qualified persons to be distributed among the medical men whose names appear on a list. The Act is not clear as to the authority of the doctor in enforcing observance of his advice or making effective his supervision, but it is to be observed that Section 56 gives to the Commission power to make regulations having the force of law, and to enforce compliance with the provisions of the Act and the regulations by penalties of both fine and imprisonment.

The Summary says the physician is to have responsibility for the health of each member of the family, and responsibility involves authority. It would hardly be reasonable to hold him responsible for matters over which he exercised no control. Moreover the Summary says that he is to be responsible for measures designed to reduce morbidity and mortality. This suggests the authoritative administration of inoculations and vaccines and possibly such surgery as the removal of tonsils. If it is the intention of the framers of this

Act to give to the medical practitioner a licence to insert himself uninvited into the health problems of the individual and to interfere and dictate in family affairs, they are launching their legislative barque on a sea of troubles in which the doctors themselves will be ultimately the chief sufferers. The family physician in this country in an age of freedom has built an estimable reputation and he will be wise not to risk his popularity by any suggestion of authoritative medicine.

Now we proceed to our second point.

EXCLUSIVELY MATERIA MEDICA

This bill is designed to create a monopoly. May I refer you to paragraph 9 of the summary, under the heading "Benefits," which reads as follows:—

Benefits—The benefits comprise prevention of disease and the application of all necessary diagnostic and curative procedures and treatments including medical, surgical, obstetrical, dental, pharmaceutical, hospital and nursing benefits and such other ancillary services as may be deemed necessary.

You will observe that there is nothing said in this sentence about any of the healing arts outside of orthodox medicine, surgery, obstetrics, dentistry and nursing. The promotion of healing by various other organized therapeutic means is quite overlooked, as is also healing by spiritual means. Medical benefits are defined in the tenth and subsequent paragraphs of the summary as exclusively what we refer to as *Materia Medica*.

Clauses 27 and 28 of the draft bill make it quite clear that orthodox medicine only is included in the intended benefits. It is only "such technical procedures and ancillary services as may be prescribed" and which are "in accordance with the regulations," which the "qualified persons" may receive. It is not likely that the medical practitioners will make a practice of prescribing procedures outside their own or allied professions, and pleasant indeed the experience should they prescribe healing by spiritual means. Moreover the prescribing must be in accordance with the regulations.

The Act defines the "medical practitioners" and "medical advisors" who furnish exclusively the services which are designated benefits, as

Practitioners in medicine, surgery, and obstetrics who are regularly qualified, duly licensed and in good standing in the province.

The Act establishes a medical monopoly in the hands of the orthodox organization.

The bill is unfair in that it discriminates in favour of one healing cult as opposed to all others.

May I add in passing that the proposal that all individuals in the dominion pay to the financial support of, and accept the teachings and the practice of, one healing method is as repugnant to us as if all the people of the dominion, Protestant and Jew, were to be asked to support financially and accept the teachings and the practice of the Roman Catholic Church; or conversely, for all residents of the dominion, Roman Catholics included, to be forced to give financial support to and to accept the teachings and the practice of a denomination of the Protestant groups. The idea that the government of Canada should establish a state medicine and force all people to yield servile obedience to it, and for all other systems to be banned, is as repugnant as for this dominion to set up one religious teaching and force servile obedience of all to it and to ban everything else.

Now we come to our third point.

OBJECTIONABLE ON RELIGIOUS GROUNDS

But it is because of its religious significance that we take our main objection. Christian Science is a religion and it is also a system of healing. It is a faithful obedience of the Master's injunction to his disciples to heal the sick and to bind up the broken hearted. The healing of the sick is an integral part and an essential element of the Christian Science religion. We understand the command of the Master to mean that we are to heal the sick by the methods which He employed, and Mary Baker Eddy, the discoverer and founder of Christian Science, has made clear in the Christian Science textbook, "Science and Health with Key to the Scriptures," that the method of the Master was a reliance upon divine aid. Prayerful study has taught is that she is right, and long experience has proven the efficacy of her teaching. Christian Science does heal the sick, just as it uplifts the well, as thousands of grateful people will testify.

Perhaps I can explain it more acceptably to some members of this committee when I say that Christian Science removes the mental and emotional disturbances which result in sickness or disease. It harmonizes the thought of the patient with the life-giving spirit of the Scriptures. "Come unto me, all ye that labour and are heavy laden, and I will give you rest." (Matt. 11:28).

We claim that the Christian Science method of healing is scientific, that it is logically understandable and that it is demonstrable.

Reliance upon material methods of healing is incompatible with reliance for healing upon divine aid. It is not possible to rely upon both. We cannot serve both God and Mammon.

Now observe what this Act proposes to do. It purposes collecting from or on behalf of every one in Canada, including all Christian Scientists, an annual sum in considerable amounts for medical services, and to persuade all men by the most powerful inducement known, to rely for their healing upon the material means which they have by law been required to purchase. If this plan is fully successful, it will destroy the Christian Science religion. It will also ruin all other systems of healing not directly benefited by its provisions, and it will fasten upon Canada an allopathic monopoly as iron bound as the present health systems of Germany.

FREEDOM IN THE PAST

The bill is obviously designed to assist the orthodox medical profession, though it is unlikely that benefit would be its final effect, but we cannot believe that the members of this committee have it in their minds to do so great a disservice to the other systems of material healing, and we refuse to credit an intention on your part to make difficult if not impossible the practice of a religion of healing. That has not been our past experience with this or any other parliament in Canada—and our experience is wide.

The practice of Christian Science is legal at common law in all the provinces of Canada, and seven of the nine provinces have specifically recognized it in favourable legislation.

In the year 1923 the province of Ontario passed an Act defining the practice of medicine, a right which only those duly registered by the medical council might exercise. A committee of the legislature heard evidence as to the efficacy of Christian Science and when the Act was passed it contained a clause exempting the practice of Christian Science from its restrictive provisions.

At the next session of the Legislature the Act which defined the practice of medicine was repealed and the Drugless Practitioners Act was enacted in its stead. The exemption of Christian Science was carried over into the new Act where it now appears, operating harmoniously without objection from anyone, and apparently to the complete satisfaction of all.

Six other provinces have granted somewhat similar exemptions and protection under more or less similar circumstances.

And why not? No one other than the practitioners of the Christian Science Church is competent to give Christian Science counsel, advice and treatment. Christian Scientists need Christian Science instruction, and Christian Science treatments, as do many others not yet members or even adherents of the church. Religious liberty is what we are asking; to deny it to us, as it is denied in this bill, would be religious tyranny.

Two years ago, Hitler banned the practice of Christian Science in Germany,—he did not like it—destroyed its literature and confiscated the church property. This bill will neither burn the books nor escheat the churches, but the effect on the organized teaching of the religion will not be greatly different, though less sudden.

We have faith to believe that were this truth crushed to earth it would rise again, but we have no fear that parliament will consent to any enactment which would have that effect.

Our present purpose is to protect our religion and our right to practice, and to depend upon the practice of, Christian Science for the cure of human ailments. The question is how under these circumstances can this best be accomplished. There may be two courses open to us. We might ask that the services of Christian Science practitioners be made available as a benefit under the Act on equal terms with, and in lieu of those of, the medical doctor.

That need cause no surprise. In the state of California, under the Workmen's Compensation Act, etc., the Christian Science practitioner is accepted in lieu of the medical doctor. He is permitted to practice his healing method in the hospitals, give instructions to the nursing staff relative to the patient, and he is paid for his services by the state. I might also add, inasmuch as I have introduced the words "nursing and hospitalization" which may cause you a little wonderment, that in that state of California we have our own hospital, which is a large spacious place in which nurses are trained to administer to the needs of the sick in accordance with our religion. They have arrived at that point, however, by a number of stages. For us to want to make that long jump in one leap is possibly more than we can hope. So I continue:—

The resulting complications of this procedure are such that after careful consideration we have decided to refrain from such a course. As we now view the bill, we are of opinion that it would be inadvisable to include Christian Science as one of the organized benefits of the system even though the cost of the benefit were paid directly to the beneficiary and he were allowed to procure his own Christian Science treatment and nursing care. Christian Science has grown in public understanding and favour while practised in freedom and we shun the limitations, complications and regulations of an organized medical system, and the too close association with material systems of healing.

EXEMPT THE CHRISTIAN SCIENTIST

The other and only remaining course is to ask that members and adherents of the Christian Science churches be given the privilege of claiming complete exemption for themselves individually from the provisions of the Act both as to contributions and benefits. This would leave them free to secure and pay for their own favoured form of treatment as necessity arises.

Such an exemption has already been granted to the Christian Scientists of British Columbia under the Health Insurance Act of that province passed in 1936 but not yet enforced. The exempting clause in that Act is as follows:—

4 (3) Where an employee otherwise within the scope of this section makes application for exemption in the manner prescribed by the regulations and establishes to the satisfaction of the commission that he is an adherent or member in good standing of the Christian Science Church, the commission shall grant him a certificate of exemption from the provisions of this Act; but, subject to the regulations, such certificate may be cancelled at the request of the employee or on the employee ceasing to be an adherent or member of that Church."

Were this clause included in the bill before this committee the word "employee" should be changed to "qualified person" and the exemption should extend to and include the qualified person, his or her family and dependents.

The regulations under the British Columbia Act are such that applications for exemption by members must be endorsed by the clerk of the church of which the applicant is a member, while the application of an adherent of the church is endorsed by a duly registered practitioner and both must bear the approval of the provincial Committee on Publication. He is the public relations committee for the Church.

By way of summary, may I say that we have pointed out:—

(1) the efficacy of spiritual healing and its importance to the Christian Science religion and to Christian Scientists,

(2) the menace which this bill contains to the Christian Science religion and its healing practice,

(3) the desirability of permitting the members and adherents of the Christian Science Church to claim exemption from the operation of the proposed Act, and,

(4) we have submitted to you a suggested form of amendment, which has been enacted elsewhere, and which we will accept as satisfactory to us. Such an amendment will interfere but little with the general operation of the Act should the parliament of Canada see fit to enact the measure.

Thus it would appear, would it not, that there is overwhelming justification for our request that freedom of religion be safeguarded? We feel that this great issue is as close to your hearts as it is to ours; it is close to the heart of every Christian, Anglican, Roman Catholic, United Churchman or Christian Scientist.

Let me close with a reference to Prime Minister Churchill. In the midst of the war, when material forces clamor unceasingly, that great man found time to look ahead. And looking ahead he said (March, 1943): "Religion has been a rock in the life and character of the British people, upon which they have built their hopes and cast their cares."

May I add to that a statement made by Lord Halifax last Saturday night in addressing the student body of Laval University, Quebec. He said: "The Nazi philosophy where the state was everything and the individual nothing could not be accepted by the Christian. The general realization of this dangerous philosophy resulted in the support for the inclusion of religion in educational programs. Once properly educated the job of the Christian student was to constantly seek to fashion the kingdom of this world more and more to the likeness of the Kingdom of God." But, I should like particularly to stress his closing remarks. "Man's real need now," said Lord Halifax, "was a knowledge of how to open his heart to God in prayer." I do not think that I could close with anything more appropriate than that.

I continue with my brief.

Religion must be free. We again respectfully ask that you exempt us from the national compulsory health insurance plan.

The CHAIRMAN: Thank you, Mr. Fulton. Mr. Fulton will be glad to answer questions.

Mr. SLAGHT: I was wondering if Mr. Fulton could tell us why on the last page, the last paragraph but two, in referring to freedom of religion, he says: "We feel that this great issue is as close to your hearts as it is to ours; it is close to the heart of every Christian, Anglican, Roman Catholic, United Churchman or Christian Scientist," and excludes the Baptist faith.

The WITNESS: I would be glad to include Baptists and have them underlined.

The CHAIRMAN: The chairman happens to be a Presbyterian, Mr. Slaght.

The WITNESS: I am sorry if I omitted any of you good friends.

Mr. KINLEY: Mr. Chairman, has the witness who presented the brief any statistics to show whether the Christian Scientists live as long or longer than any other people in the world?

The WITNESS: Well, now, that is a little difficult, but I can just tell you from my personal experience—you know, things that are close to our hearts are close,—my mother was slated to die from heart trouble when she was fifty-six; she lived to be seventy-six. Perhaps we are not going to accomplish that longevity program all in one life. I think the point to see is this: is the life of the individual Christian Scientist lengthened by those teachings? Some people say we proselytize or take from the other religions; we do not; we take from the graveyard, so none of you need be disturbed over that. Our hope in that direction, and what the Christian Scientists take care of—and as a practitioner I speak from experience—a large part of our work is taking care of those individuals whom no human aid could help and it lengthens their life, but I have no specific statistics.

Mr. FULFORD: Mr. Chairman, I should like to refer to the following sentence on page 1: "Yet our concern, as a church, is not with debatable economics; it is with undebatable religious principles." So it does not look as if we can get very far in any sort of debate here. However, I should like to ask Mr. Fulton a question.

By Mr. Fulford:

Q. What do Christian Scientists do in other countries where health insurance is an established law?—A. Well, I think perhaps we should point out that this Act is much more wide and sweeping than others. For instance, here it is made responsible for the healing of the whole family. In most other places it is a case where individuals are ill and receive their benefit. This is wide-sweeping and all-embracing coverage, which is a thing which causes us so much grave concern. I think Mr. Eckman, one of our associates here, would be glad to amplify that.

By Mr. McGarry:

Q. May I ask Mr. Fulton a question? In the Acts where you have been named as an aid for healing, do your people take any courses in the science of medicine, material medicine?—A. No; they do not base their treatment on the diagnosis of disease, even as did Jesus. I do not recall in the Bible any place where He called in a doctor to diagnose a disease. The man born blind and the man with the withered hand and so on were all handled by prayer. Now, that is the advantage in this system, because prayer is not limited to a chemical law. If you guess your disease right and administer the proper medicine we will hope that you reach a favourable conclusion; but you are limited to a correct diagnosis. Prayer is not limited, even as the Bible says, the word of God is quick and powerful, piercing even to the bone and the marrow, so it heals that which is both seen and unseen, and therefore it is not based on diagnosis.

Mr. ECKMAN: Mr. Chairman and gentlemen, it is not possible for me to add very much to the very able presentation of Mr. Fulton, but I will attempt to answer Mr. Fulford's question with regard to the practices in other countries and by way of explanation will say that I am manager of the committees of publication throughout the world. Mr. Fulton was one of our committee for many years in Ontario. Mr. Van der Voort is now the committee for Ontario. The method the Christian Scientists have followed in different countries is this: In Britain we have a large number of churches probably 150 or so—I cannot tell you the exact number. The constituted authorities there all recognize Christian Science by recognizing nursing homes set apart for Christian Scientists' practice. We have a large number of Christian Scientist practitioners who carry on both the healing of the sick and the saving of the sinner according to our teachings, and they are doing it successfully without any obstruction or objection by any constituted authority.

The greatest growth of Christian Science has been in the United States, and probably the greatest growth in any part of the United States has been in the state of California, of which I am a resident. I live in Los Angeles and am temporarily sojourning in Boston. In California there has been a very substantial growth. There are approximately 300 churches in California. We do not number our people in accordance with the provisions of our manual and according to scriptural edict, which is the fundamental basis, so we are not prepared to give the type of statistics that human organizations and business organizations as a rule are prepared to give and do collect. But I can say this: In California there have been several situations where social insurance and health insurance have been offered and because of the unwillingness of our good friends the doctors to include the exemption clause in the bill the bills have been uniformly defeated in California. I do not say that in any sense of a threat at all, but merely to have you realize that with the growth of Christian Science, where it is permitted to grow, there is an intelligent citizenship that votes down any government and protects the right of personal freedom as well as the right to the healing which the Christian Scientist definitely relies upon. In referring to the healing phase may I say it is only the sign, as Moses said, to evidence the fact of its definite authority; and we feel that if anything should interfere with that or destroy that it would not only interfere with our civil rights but it would destroy our religious practices.

The CHAIRMAN: Mr. Kinley, have you something to say?

Mr. KINLEY: Mr. Chairman, I wish to rise to tell the committee I have received quite a few telegrams from Nova Scotia, all expressing concern over what they think will be an attempt to restrict their religious liberty. I shall not read the telegrams, but I shall give the names of those sending them. One is from Miss Alice M. Hatfield, Yarmouth, Nova Scotia; another one is from John W. Farr, North Sydney, Nova Scotia; another one is from T. E. Powers, Committee of Publication, of Nova Scotia, Halifax, Nova Scotia; another is from Wallace Nauss, Lunenburg, Nova Scotia, and another one is from Lt.-Col. Spencer Ball, 1st Reader, and George W. Stairs, clerk, Halifax, Nova Scotia. I just wish to say that I acknowledge receipt of these telegrams. These telegrams are from responsible people whom I know in Nova Scotia, and I am interested in their work.

The CHAIRMAN: Dr. McCann?

Mr. MCCANN: Mr. Chairman, I have listened very attentively to the brief which has been submitted, and I may preface my remarks by saying that I have the utmost regard and the utmost respect for the religious belief of any individual in any country. I would not deny to anyone the right to exercise that right at any time and in any place.

On page 2 of the brief I find the following: "We purpose confining our remarks in the main to these features of the suggested enactment which are restrictive of religious liberty—"

Now, there is nothing in this piece of legislation which has to do with religious beliefs or religious practices of any sect whatever. This bill as I understand it has to do with the material health of people, not with their spiritual health. Now, I am quite sure that the speaker will recognize this, that members of every faith take advantage of certain measures; or will take advantage of them and have taken advantage of these measures which are in effect—they have to do with preventive medicine. A great part of this bill as indicated will have to do with preventive measures. And now, he I think will agree with me that members of Christian Science, if they have children in schools, have certain protection which will come under the health authorities. For instance, even the purification of the water supply, the collection of garbage, street-cleaning; all these things are preventive health measures. The Christian Scientist, in company with every other religious sect to-day, takes advantage of these facilities which are offered to them and the added facilities which will be offered in the event of health insurance going into effect. And now, I ask him: does he not think that Christian Science, and every other religious group, should make a contribution toward the cost? If, as it is proposed in this brief Christian Scientists are entirely exempted, then those people who are contributing to the public health scheme will be paying part of that cost for others to take advantage of, and those who do not contribute to it will be taking advantage, getting assistance from it. May I ask the gentleman who presented the brief—I think his name is Fulton—what would be his position with reference to Christian Science? And I ask this question respectfully, not in derision at all, if someone coming up to Parliament Hill, up here to the buildings, this morning had happened to be hit by a street-car and had had his leg severed; would Christian Science heal that wound, or would he have to resort to the allopathic or surgical system to minister to it; or, supposing he had a fracture, or something like that. I am a believer, and say to you that I believe in the efficacy of prayer, and I make open declaration of that here now; and I have respect for other people who do; but after all, prayer in a great many instances is to give people direction as to what to do. And so I submit to the witness that that is my view with reference to the tenets of his faith; and I ask him respectfully to give me an answer to the question posed by the case which I presented hypothetically just now.

The WITNESS: I am in agreement with you, Dr. McCann, with respect to the hypothetical case where a person had his leg amputated. Our brief distinctly states that anybody should be taken to hospital for necessary attention in the way of binding or sewing up a wound. I would say this—and I am quoting again from my own experience, if you will pardon me—my little boy fell and had a very bad cut. Fifty-six stitches were required. We required to have that service there at that time, we paid for it, not the state. And the nice part of it was that the time that little boy was in the cast was a little over one-half the time that had been expected, and his freedom of movement was correspondingly within half the time.

Mr. McCANN: But it was not because it was put on by Christian Scientists.

The WITNESS: I agree, and say in cases of a damage of that kind you should have—and we appreciate—surgical assistance; but I do say this, that the healing effect will be quicker, the applications will be fewer, and the likelihood of permanent healing without damage will be improved very greatly. But that is a small part. I have four children, totalling in age about sixty years. That is the one and only time where one of those children has had surgical or medical care; and they are the healthiest—may I say, too, that one of my boys when he was

born because an arm was pulled in its socket it was said that the arm would never grow; and I would be happy, Dr. McCann, any time to have the privilege of introducing to you that fine strapping chap now fourteen years of age, five feet eleven inches tall, weighing 168 pounds—you cannot tell the difference between the two arms.

Mr. McCANN: Yes, but you are giving us individual cases; how about the principle of the thing? You accept the principle that in instances you must call in men who are trained scientifically in the practice of medicine or surgery; now, the point is this, taking that for granted: the principle is this, that these advantages are open to anybody under a health insurance scheme. That is the conclusion that I would come to, that that being the fact your sect should contribute to the general cost throughout the country in that regard.

The WITNESS: On the other hand we are not placing any charge on the act for medical or surgical care.

Mr. McCANN: I understand that.

The WITNESS: Because we are willing to pay ourselves.

Mr. McCANN: But should you not help out for the other fellow; that is a pretty good religion too.

The WITNESS: We do, in sanitary measures. You mentioned the collection of garbage; now I have it in my brief that we approve of support of sanitary measures. But, may I say something else lest we leave the impression that the children have to take preventive measures. I would like again to answer you by the acts of the province of Ontario, acts which have been passed after mature consideration which have been in effect for years and which are functioning harmoniously; namely, the Christian Science child in the province of Ontario is not compelled to undergo medical examination or inspection, other than for communicable diseases, of which we approve.

Mr. McCANN: Neither is any other child in the province of Ontario. Now, let me ask you this: (we may as well get the record straight) and now, with reference to disease—take for instance, if you want to toxoid children against diphtheria—we of the allopathic school of medicine believe in the efficacy of toxoid inoculation against diphtheria—but when that is done in a community a request card goes out to the parents of that individual child asking that they give their consent to having it done. Now, get away from this idea that people are, taking children in school, held down by compulsion and given these inoculations; that is not the case. The only case in Ontario that there is is that there is a law in effect that children shall be vaccinated against small-pox; and that law is observed more often in the breach than it is in practice, it is not carried out; but with reference to other inoculations—for communicable diseases, that matter rests entirely with the people. We recognize the importance and the significance of parenthood and the significance of the home; and that further the fathers and mothers have the custody of their children, and we are trying in co-operation with them to teach them by pointing out to them the benefits of these things. Let us get away from this idea that in Ontario at least—and I think I speak for the whole of Canada—these acts are compulsory. I doubt very much if they will be compulsory under any health insurance scheme. They will be suggested to people, and an attempt will be made to educate them along those lines; and a practical approach is now being made. When you get a great city, like the city of Toronto or like the city of Hamilton, going for years without a single case of diphtheria because of inoculation, that in itself is ample proof.

Mr. FULFORD: Further to Dr. McCann's remarks; it happened that just yesterday I had to sign a document allowing the school authorities of the town

of Brockville to take a drop of blood from my son for a tuberculosis test; so, certainly, there is nothing compulsory that I see in the Province of Ontario.

The WITNESS: I am very glad indeed that this subject of compulsion has come up, very glad; because that is a heavy subject. Now, I do not find in this act anything that says it is not compulsory. Now then, if it is not compulsory, I ask you please, write it into the act.

Mr. LALONDE: You say in your brief at paragraph 3, that, "if such an exemption be granted it should be the same as what has already been granted but not yet endorsed by the British Columbia Act." Would you be good enough to tell me why it has not been endorsed? Then, secondly, on page 8 I read this: "No one other than the practitioners of the Christian Science church is competent to give Christian Science counsel, advice and treatment." I would like to have a precise definition of what you mean by, "practitioner"; is he a doctor, a man who has some knowledge of medical science; or, is he one who has a diploma or something else. I would like the witness to give us that information.

The WITNESS: First, answering that question regarding the British Columbia Act: I cannot say, I do not know why that bill has not been put into force; but, nevertheless, the exemption is there. Now, as to answering your question regarding the Christian Science practitioner, whether he is one who is qualified by medical education and diploma and so on: no, he is not. He is one who has set his life for years to the study of religion and the laws of God, not the laws of the human body or matter; and he exercises prayer in the utilization of that law. Then, these individuals must produce satisfactory proof to the board of directors of the mother church in Boston proving that in their experience they have been able to demonstrate this law in the healing of sickness; but no one—except among members of his own associates perhaps—is able to put his name down as a public practitioner of Christian Science until he has produced irrefutable proof that he has sufficient understanding of the Bible; and in most instances, (there are very few exceptions) has taken a course in a study of the laws of God and their application to the solving of human problems.

Mr. HANSELL: Mr. Chairman, I am not a member of this committee—

Mr. ROEBUCK: Mr. Chairman, may I just have a moment: it was arranged that we should take an hour and fifteen minutes. That time has now elapsed. If the questions and answers go on it would be at the expense of the following delegations.

The CHAIRMAN: I was just going to take one more question.

Mr. ROEBUCK: Very well.

The CHAIRMAN: Mr. Hansell:

Mr. HANSELL: Mr. Chairman, I am not a member of the committee, but I was asked to sit in this morning by one of our men who finds it impossible to be here. I do not think one member of our committee would disparage in any respect whatsoever the subject matter of religious freedom. However, there is a principle involved which I see, which I would like to ask the witness. This bill that is proposed, or the health measures that are proposed in the bill, provide for medical care to be given to all members of the family including of course the children from their infancy right along through the years. Now, what I would like to ask the witness is this: I have some little knowledge of the philosophy of Christian Science; perhaps just enough to make my mind completely confused; but I would like to know how Christian Science would treat an infant child or one who is not able or old enough to exercise the medium of prayer for their healing? I ask this because there is a very vital principle involved in it. I have a friend—Dr. McCann has referred to a case

where a leg was severed by a street car—I am not reciting this case to be dramatic at all. I have a friend whose very young child was taken sick, and this friend, the mother of the child, was given some instruction by the Christian Science practitioner. The child died. Of course, I know the argument to that is that the child might have died anyway, but the result of the case is this, that the woman was evidently advised she should not call a doctor. She took the advice and did not call the doctor. The result was that the child died. The woman realizing that the child's life might have been saved had she called a doctor was eventually taken to an insane asylum. I say I do not recite that to be dramatic. It is a case that I know of personally. It is not one I read in a book. I am not disparaging at all the Christian Science method of healing if they in their own church desire to carry it on but I would like an answer to that because I believe in this scheme we have here. It gives the privilege to parents of giving medical attention to their children.—A. I want to thank you for the question. A child does not lend its co-operation to anybody. It does not lend its co-operation to a Christian Science practitioner, as you say, and neither does it lend its co-operation to the doctor. The case is determined by the parents. They ask the doctor to come. He administers the chemical, or otherwise, to that child. In the Christian Science case the parents get in touch with the Christian Science practitioner and the practitioner provides the form of treatment of which they are capable. The cases are identical. I would like to refer you back to that case which I mentioned, a child who had a pre-natal condition and walked with head and shoulders away back and one foot short, and that was determined by four doctors at ten months. Christian Science treatment was requested. The child walked normally at sixteen months and was completely healed at two years. I trust that touches the point a little.

The CHAIRMAN: On behalf of the committee I should like to thank Mr. Fulton and his associates from the Christian Science Church for their brief and for their attendance here to-day.

Mr. ADAMSON: May I ask one short question?

The CHAIRMAN: Make it short.

By Mr. Adamson:

Q. Regarding industrial accidents I have some experience of my own. Supposing a shift goes on duty and there is a rock burst. Some of the miners are Christian Scientists and others are not. The accident insurance under this bill takes care of all. What are you going to do with the Christian Scientist miner who suffers an industrial accident? I know several cases where that has happened.—A. I would ask Mr. Eckman to answer that because he is acquainted with California where the Workmen's Compensation Act approves of Christian Science treatment along with medical care.

Mr. ECKMAN: Briefly the answer to that is this, that we have admitted and Mr. Fulton has admitted, that if there is a physical condition which needs to be handled where a fracture or other accident occurs, we do have the hands and fingers of the experienced surgeon to repair these conditions of a physical character. In connection with the Workmen's Compensation Act—I speak again of California because my experience is greater there—and the industrial accident board, which is a state board, and covers private carriers operating in California—I think there are only two states where that is the case—in these accidents Christian Scientists do submit of necessity to examination by a physician, sanitary measures, cleanliness, binding to prevent the undue flow of blood, and so forth. For instance, if it is an amputatoin naturally a surgeon will perform that amputation. If it is a fractured bone the surgeon will set that bone. Then Christian Science treatment is applied. It is not that we are

seeking to exclude ourselves from these things for in our present experience we do not feel we have attained to that complete demonstration of the spiritual man which we know to be in the image and likeness of God. We believe the scripture when it says that man is made in the image and likeness of God, and that this human structure which seems to express man in our present experience does need certain of these applications. In California after these temporary measures are had then the practitioner is employed with the physician. Compensation is paid, and if the practitioner's time is given the practitioner is likewise compensated. That leaves Dr. McCann's question. It is not our purpose and we are never, as taxpayers, disposed to avoid any right or legal obligation on our part and we go the full way. However, we feel that the question of sanitation is a fundamental thing which so many of the countries of the world need as well as the United States and Canada, where cleanliness is necessary to stamp out smallpox and other conditions, as Mr. Willkie brought out so well in his book recently, but these people do not require medical attention of a compulsory character and as Mr. Fulton has so well said in his closing if this is not intended to be compulsory then put the exemption clause in which we ask and that is all we are seeking.

The CHAIRMAN: Thank you very much. We are to hear now from the optometrists' board of examiners.

Mr. ROEBUCK: Mr. Chairman, just as we were commencing the hearing of the previous delegation you said to me that counsel were not heard.

The CHAIRMAN: That is right.

Mr. ROEBUCK: I was not quick enough perhaps in seeing the significance of that statement. You must know, Mr. Chairman, that any member of parliament can be counsel in opposing a bill before a committee of the House.

Mr. CHAIRMAN: Or supporting it.

Mr. ROEBUCK: I cannot allow that statement to stand on the record. I came here as a member of parliament exercising the function which members of parliament frequently do of introducing delegations from their own constituencies and their own province. That is what I was here for, and I intended to introduce this delegation with a very few remarks. I was jarred out of saying anything, and perhaps that was just as well, but I wanted it clear on the record.

The CHAIRMAN: All right.

Mr. ROEBUCK: I am not here as counsel at all.

The CHAIRMAN: Lawyers usually are counsel.

Mr. ROEBUCK: Perhaps I have given counsel and will again, but it is all right as long as we are clear on the technical position which I occupy.

I have been counsel to the Christian Science Churches, though not a Christian Scientist, for many years. I suppose for twenty-five years I have advised committees on publication and the public relations committee of that Church on various matters affecting the law, not so much religion. I may say this, that in my long experience I can tell you flatly that no practitioner who knew his business or had any common sense would ever advise a parent not to call a doctor for his child if his child is seriously ill. We have thoroughly established that as a practice among the practitioners of the Christian Science Church and the proof of it is that they are very seldom in trouble. They have no quarrel with the medical profession. Most doctors and practitioners get along very well indeed.

I just happened to come across a quotation from one of our law books which I think would perhaps close this subject nicely. It is from Bishop on Criminal Law, section 494:—

While the public has an interest in the health of its several members, every individual has a right of his own health specially in his own keeping. But not infrequently legislators, with zeal burning more brightly than wisdom, undertake to regulate men's health to the point of infringing their own private and rightful jurisdiction and control.

Let us hope that this bill will not do that.

We turn now to the next delegation which I also, as a member of parliament, have the honour to introduce. It is the Optometry Board of Examiners, a statutory institution in the province of Ontario. I ought to know something on this subject, because as attorney general of the province I drew the bill that now constitutes these people, the governing body of the optometrists of the province. The last delegation was no doubt highly combative with many disagreements. I think this one will be quite the reverse because I see among the middle-aged gentlemen who form the body of this committee that most of them pay tribute to the optometrists by wearing their glasses. The spokesman for the delegation is Mr. George Bagwell. With the delegation is Col. Cooper, the secretary of the board, and Mr. Fisher, one of the lecturers of the School of Optometry.

GEORGE BAGWELL, *called*

Mr. COTE: At this point might I be allowed to draw your attention to a particular point? I see that there is only left thirty minutes for the optometrists to present their case to this committee. I respectfully submit that it would be unfair to the profession, first because they have to plead the case of a profession which has been completely overlooked in the draft bill, so that on that ground they should be allowed as much opportunity as those professions who have already been provided for in the bill. Secondly, if they are limited to thirty minutes it would be unfair to those delegates who have come a long way to be here. There are with us here this morning some officers of the Canadian Association of Optometrists who have come from the prairie provinces and from the maritimes. I just wish to draw your attention to this so that fair treatment may be given to them.

The CHAIRMAN: If we can proceed Mr. Bagwell will take fifteen minutes.

The WITNESS: Mr. Chairman and members of the special committee: the brief that I am about to present to the committee is the brief of the Board of Examiners in Optometry appointed under the provisions of the Optometry Act, and who administer the provisions of that Act. I suppose about fifty per cent of the practising optometrists of Canada are registered with the board. It was thought that the views of the board as to this proposed legislation should be laid before the committee so they may have the advantage of them, and I hope that their suggestions may be adopted when the legislation is enacted.

The Board of Examiners in Optometry appointed under the provisions of the Ontario Optometry Act, being Revised Statutes of Ontario, 1937, Chapter 246 and amendments thereto, is the official body appointed by the government of the Province of Ontario by order in council to administer the Ontario Optometry Act. Under the Optometry Act, the Board of Examiners have vested in them the administration of the Optometry Act and the regulations made thereunder. A copy of this Act, together with a copy of the regulations made by the board pursuant to the powers conferred upon them by the Act, as approved of by order in council, is hereunder annexed to this brief.

Under the Optometry Act, an optometrist is defined as meaning any person who practises optometry and "optometry" is defined as meaning the measurement of or the attempt to measure by any means *other than by the use of drugs*,

the refractive or muscular condition of the eye, the prescribing of any ophthalmic lens or lenses or the prescribing of any spectacles or eye-glasses or ocular calisthenics to any person for the relief or correction of any visual or muscular error or defect of the eye.

It will be noted that the Optometry Act limits optometrists to the measurement of the refractive or muscular condition of the eye and the prescribing of ophthalmic lenses or spectacles for the relief or correction of any visual or muscular error that the patient is found to be suffering from or the prescribing of ocular calisthenics for the relief of such a condition but that the use of drugs is prohibited.

The optometrist does not and has no legal right to treat "diseases" of the eye in the sense of injury to the eye or infections on other disease conditions of the same. It is pointed out, however, that many persons suffer ailments and disabilities, such as headaches, nervousness and kindred disabilities which are the direct result of and flow from some visual or muscular error or defect in the eye which the optometrist is qualified and entitled to correct by the prescribing of proper glasses or ocular calisthenics to correct the situation and by this remedial treatment remove the source of the headaches or other disability.

I suppose that most of the people here today who are wearing glasses went to get their glasses due to some headache or feeling of fatigue or some other disability which brought to their mind and their attention the fact that they needed some relief for eye trouble from which they were suffering.

The Board of Examiners in Optometry operate the "College of Optometry of Ontario", specific authority for the creation and operation of the college being contained in the Optometry Act.

The College of Optometry in Ontario founded and operated by the board is situated at the city of Toronto, adjacent to the University of Toronto. Before any student is allowed to enter the college to take the optometrical course, he is required to present evidence of having passed his honour matriculation in Ontario or its equivalent. The course itself is a three-year course covering biology, mathematics, physics (general), physics (optics), psychology, physiological optics, optometry, mechanical and applied optics, anatomy, neurological optics, recognition of disease, economics, accounting, light and vision, physiology, optometrical Praxis, and jurisprudence. The minimum number of teaching hours in this 3-year course is 2700 hours.

You will see that the optometrist is one who must first have his honour matriculation and then must take this three year course with a large number of his subjects being taught by the university.

The college works in close co-operation with the University of Toronto and the majority of the subjects given are taught at the university whose laboratory and other facilities are available to students of the college. A calendar of the College of Optometry setting out in detail the courses of instruction and subjects taught is attached herewith. At the present time there are approximately 800 optometrists registered with the board and entitled to practise in the province of Ontario, and to prescribe and supply glasses and spectacles to persons found by them to be suffering from visual or muscular error or defect of the eye. There are approximately 1500 practising optometrists in the Dominion of Canada.

In Ontario alone, a careful check-up shows there were last year at least 450,000 prescriptions for eye-glasses and spectacles prescribed and furnished by the optometrists of this province. In the Dominion of Canada as a whole, there were approximately 1,220,000 prescriptions for spectacles and eye-glasses furnished by optometrists to patients found to be suffering from some visual or muscular error or defect of the eye. These figures are in addition to

any prescriptions for eyeglasses or spectacles that may have been furnished through the medium of medical practitioners specializing in eye work. It is obvious from these figures that a large proportion of the population of Canada is dependent upon the optometrist for the relief and treatment of the visual or muscular errors or defects of the eye that they may be suffering from, just as they are dependent upon the dentist to relieve them in the case of defective teeth or the medical practitioner to help them in the case of disease or disability of the body. It is significant, however, that although the medical needs and the dental needs of the population have been provided for in the draft act by including the medical, dental and nursing professions, that there is no mention made in the Act of the profession of optometry. It is surely beyond argument that the state of an individual's eyes, perhaps the most essential organ in his body, should have at least the same concern as his teeth or any other portion of his anatomy. It is respectfully submitted that any health insurance legislation which does not include and make available to the public generally the services of the optometrist would be quite inadequate and would fail to achieve its purpose, which, as we understand it, is to provide proper health services to each individual citizen of the country.

The optometrists of Canada in providing relief to the thousands of persons found to be suffering from visual or muscular error or defect of the eye, whether brought about by old age, muscular imbalance or otherwise, are providing a vital and essential health service to the people of Canada. An individual suffering from visual or muscular error or defects of the eye is just as much entitled to receive treatment and correction for this disability by having proper glasses prescribed for him as he is entitled to receive dental treatment for defective teeth or medical treatment for other ailments or diseases of the body.

It is conceded that visual or muscular error or defect of the eye can be the cause of serious disability to an individual, such as headaches, nervousness and fatigue, and if not corrected by the prescribing of proper glasses can render him incapable of carrying on his ordinary duties. The proper care and treatment of visual errors or defects of the eye is a first essential to the health of the nation, and no health insurance scheme would be complete or satisfactory which did not provide for such care of the eyes.

The citizens of Canada have come to depend upon the optometrist to provide them relief from visual or muscular error or defects of the eyes. It is common knowledge that a person suffering from or having trouble with his eyes goes first to an optometrist where, if the trouble is found to be due to visual or muscular error or defects for which the prescribing of proper glasses is the proper treatment, such prescription is made; and, on the other hand, if the trouble is due to disease or infection of the eye, he is referred to a physician or eye specialist. It is only the rare case that the trouble is due to disease or infection, the great majority of eye trouble being due to visual or muscular error or defect. The medical profession is quite incapable of handling or dealing with the problem of visual or muscular error or defect of the eye as distinguished from disease or infection of the eye. The ordinary physician does not attempt to handle this type of disability and it is only the occasional oculist or doctor, specializing in eye work, who has the necessary experience to give a proper prescription for the spectacles or eye-glasses that are needed. It is quite obvious that if the hundreds of thousands of Canadian citizens now depending upon the optometrist to detect and correct errors of refraction, accommodation and associated functions of the eye, are required to go to a physician, or medical practitioner if they are to participate to advantage in the health insurance scheme which they will be contributing to, that the medical profession will be wholly unable to cope with the situation, there not being sufficient medical men specializing in ophthalmology

to handle the tremendously increased number of patients they would be required to attend to. There are just not enough physicians and surgeons specializing in ophthalmology, or oculists, available to undertake the treatment of the tremendous number of patients that they would be called upon to handle if the profession of optometry is excluded from this, and there would be some public reaction resulting.

The exclusion of the optometrist from the provisions of the Draft Act raises the situation that each member of the public will be required to make his annual contribution to the fund, but will be restricted to a medical practitioner if he needs glasses to correct his refraction or accommodation of the eye and the treatment of which and correction of which is just as essential to his health and well-being as the correction and treatment of any other form of disability is, and if he wishes to go to his regular optometrist he will have to do so at his own expense and without any help from the fund which his payments have helped to create. This would be a grave injustice to the 1,500 practicing optometrists in the dominion as well, because the average person faced with the question of having to pay his optometrist for an examination out of his own pocket, or being able to obtain an eye examination from an eye specialist under the terms of the proposed Act, would naturally choose the one which required no outlay on his part but which would be covered by payment from the fund to which he has contributed.

It has been suggested that the dominion legislation would take the form of a supervisory and enabling Act with the administrative and executive legislation being left to the individual provinces. It is respectfully submitted that if this is the case, that the Dominion Act be so worded as to place no handicap on the provinces, so as to enable the services of optometrists to be included on the same basis as medical men, dentists and nurses. As each province will as heretofore administer its own medical and other health acts, that accordingly the dominion legislation should not make it impossible or difficult for the provincial legislation to cover such services as are rendered by the optometrist. The optometrist is recognized by law as having the right to treat members of the public for visual or muscular error or defect of the eye and a large proportion of the population being dependent upon them in this regard, it is accordingly submitted that it would be unjust, and inequitable for legislation to be enacted which would exclude them from carrying on this very necessary and very vital public health service.

The Board of Examiners in Optometry for the Province of Ontario as the governing body of the Ontario optometrists presents these facts and submissions to the committee for its information and consideration and with every confidence that adequate provision will be made in any proposed legislation to meet the situations described herein.

All of which is respectfully submitted.

BOARD OF EXAMINERS IN OPTOMETRY,
PROVINCE OF ONTARIO,

H. S. COOPER, *Secretary.*

Mr. McCANN: Might I just take a moment to point out to the optometrists who are here that I do not think there need be any great apprehension on their part with respect to carrying on their business just as it is carried on at the present time. I would refer them to section 27 of the proposed bill which we have before us; to section 27, sub-section 2 which reads as follows:—

For the purposes of this Act the benefits referred to in the last preceding subsection shall be administered under the following heads, namely,

- (a) Medical, surgical and obstetrical benefits.
- (b) Dental benefit.
- (c) Pharmaceutical benefit.
- (d) Hospital benefit.
- (e) Nursing benefit.

(3) The benefits referred to in the last preceding subsection shall include such special and technical procedures and ancillary services as may be prescribed—

Mr. ROEBUCK: By whom?

Mr. McCANN: By the attending physician.

Mr. ROEBUCK: And that means that you have to go to a physician first, does it not?

Mr. McCANN: It might, but not necessarily. You could do just as is being done at present, go to the optometrist yourself.

—and as may, in accordance with regulations made hereunder, be deemed necessary to make effective the said benefits in the case of any qualified person."

My contention is that there is practically no restriction in the carrying on of the work of optometry under the act; that these people will be referred to optometrists just as they are now in a great many instances. I do not quite agree with the gentleman who presented the brief that a great percentage of the people consult the optometrist first; I would say that a greater percentage of the people consult the family physician first and that he perhaps without a written order advises them to consult an optometrist, or in some instances a specialist in eye diseases. So I cannot see that there should be any great apprehension on the part of the optometrist; and my own thought in the matter is they would continue to do as they are doing at the present time, and as they have always done in the past. However, I may be wrong in that.

The WITNESS: My information, Dr. McCann, and I assume it is reliable, as we had a discussion on it the other day, was that a great majority of the patients go to the optometrist first; and, as I pointed out in figures here (and I think they are accurate) they run into hundreds of thousands who go to the optometrists in the first place on their own initiative. And the objection that the optometrists take to the situation created by the bill, as I read that section on ancillary services, is that it is quite true that the doctor can refer the patients to an optometrist to have his eyes examined and refractions made and glasses prescribed; but under the item as it stands they first have to go to the physician and have to be referred by the physician to the optometrist; but generally they don't do that, they refer them to a medical specialist specializing in the eye, and they have to make out a prescription.

Mr. McCANN: Is there anything you see in the bill that prevents them from doing that on their own hook? While it is not definitely stated in the bill they will get all the benefits of it, my interpretation of it is that they may continue to do that.

The WITNESS: But, at their own expense.

Mr. McCANN: At their own expense, exactly.

The WITNESS: If they are going to contribute; if eyes are vital to health, and if people wearing glasses are going to contribute to the fund; surely, they should have the benefit of the fund to which they are contributing and be able to go to the optometrist who has given them satisfactory service for many years.

The CHAIRMAN: Before having any further questions we will hear from the Canadian Association of Optometrists, as the two organizations are allied.

Mr. H. S. McLUNG, called.

The WITNESS: Mr. Chairman and members of the committee: it is wise that I should curtail my remarks very greatly and I am therefore going to read just a few lines and then, with the Chairman's permission, ask that our brief be taken as read and placed on your record, along with the brief from the province of Quebec, and the brief from our secretary, Mr. Bind—he is the secretary of the Canadian association. I believe there is some considerable confusion in the minds of some of you, if not in the minds of the majority of you, as to the set-up of Canadian optometry; therefore, I am going to read you a few lines to clarify your minds on that point, and then as you wish about hearing the briefs. I shall read it.

As there is an obvious lack of understanding of organized optometry in Canada, I shall very briefly outline it.

In 1904 Quebec recognized the necessity of regulating the practice of optometry and put the first Canadian Optometry Act in its Statutes. In 1909, Manitoba, and in 1911 my own province Saskatchewan did the same and defined the practice as a profession which "employed any means other than drugs, medicine or surgery for the measurement and aid of the powers of vision". During the next few years each of the other provinces passed a similar optometry act.

Two years ago elected representatives of each of the provincial optometric associations met and formed the Canadian Association of Optometrists supported and representing all Canadian optometrists.

Such briefly is the set-up of optometry in Canada. Many years ago the necessity of an optometric college to instruct students in optometry was felt. Quebec has for a long time had such a college which is now part and parcel of the University of Montreal. The other provincial associations of Canada voluntarily and annually gave financial support in the organization of another college in Toronto until it became self-supporting. This is now known as the Ontario College of Optometry. And that was the college to which reference was made by the last speaker. That originally was put on its feet by the Canadian optometrists and handed over to the Ontario board and is now under that board.

All the provinces carry on educational programs for their graduate licentiates to keep them up to date in the rapid advancement in optometric knowledge. For example,—Saskatchewan's postgraduate course at Saskatchewan University. We in Saskatchewan are proud to have the wholehearted support given by lecturers from the medical faculty.

Examinations in optometry are controlled and conducted by Canadian universities. Admission for examination requires a three years course in a college of optometry of acceptable standing.

And now, I am not going to inflict any more of my remarks on that subject to you. If it is agreeable to your committee, and with the consent of the Chairman, I would ask that the rest of our brief be put on your record and taken as read. Then, I will call upon Mr. Hebert to speak to you with respect to the province of Quebec.

The CHAIRMAN: Thank you, Mr. McClung. Your brief will appear in the record of our proceedings today.

THE CANADIAN ASSOCIATION OF OPTOMETRISTS

is officially representative of practically all Canadian optometrists through their provincial associations with a total membership of approximately 1,500 licentiates. It is a reorganization of the Dominion Optometrical Association and its constitutional objects are as follows:—

- (1) To consider and act upon all matters which have Dominion-wide effect upon optometry and which do not lie specifically within the jurisdiction of any individual province.
- (2) To promote by all means possible the usefulness of optometry to the people of Canada.
- (3) To promote good fellowship and friendly intercourse between the several provincial associations.
- (4) To advance optometric education.

The Practice of Optometry is governed by optometry acts on the statute books of every province in the dominion, and according to the Saskatchewan Act means "the employment of any means other than drugs, medicine or surgery for the measurement or aid of the powers of vision or the supplying of lenses or prisms for the aid thereof." Definitions in the other provincial acts have a similar interpretation. We believe that optometry is an essential part of national health service because through the application of this separate branch of technology a major part of the community secures good vision, improved visual efficiency and consequential health benefits.

Optometry should be considered as a direct outgrowth of the science of optics, a branch of physics, and while it impinges on other sciences it is essentially the application of physical methods to the vital act of vision.

Optometry is concerned with the function of vision and the lighting conditions under which vision occurs; with the correction of functional anomalies of vision; and with all appliances that aid vision, their theory, design and application.

The optometrist is one capable of performing a specialized and essential work in the health service of the community, and should be afforded the status accorded to those of other professions within the health service.

Refraction (the determination of the refractive errors of the eye and their correction by glasses) is no part of medicine and there is a large-scale need of skilled refractionists trained as such and not necessarily as practitioners of ophthalmic medicine or surgery.

70 per cent of the population have so-called defective vision. In the 40 age group, 48 per cent have imperfect sight, and from here on eyesight fails rapidly; at age 50, 71 per cent; at 60, 82 per cent; and at 70, 95 per cent. A study conducted in Philadelphia jointly by the American Medical Association and the National Education Association found on the basis of a survey of 200,000 children, that 20 per cent of the total suffered from visual defects. Childhood is the most crucial period in life. We cannot afford to gamble with the health of the children of Canada. The inevitable conclusion is that these defects must be corrected and the optometrist must be given his part in this work.

Let us consider *the important part that refractive errors and muscular incoordination play in regard to general health*. The correction of these defects is purely optometric, but to absolve ourselves from charges of exaggeration, we are taking the liberty of quoting from international medical authorities, one British and one American. We bring as our first star witness, Sir Stewart Duke Elder, F.R.C.S., Examiner in Ophthalmology, Royal College of Surgeons of England and Royal College of Physicians, London, who states in "The Practice of Refraction"—

It is not surprising, therefore, that of all the ailments which interfere with smooth-running of the human machine, eyestrain in one form or another is probably the most common.

The importance of the relief of eye-strain in the health and happiness as well as in the economic value of the individual, is now widely recog-

nized; but at the same time it is surprising, when the various constitutional troubles to which it may give rise are remembered, that the mention made of it in the majority of works on general medicine is so slight and casual.

Tradition dies hard; and this apathy is probably due in large measure to the complete neglect with which the subject was regarded until comparatively recently by legitimate practitioners.

But the ill-advised statements of a few should not result in our ignoring the fact that errors of refraction, more especially of small amount, anomalies of accommodation and convergence, and a lack of balance between the extrinsic ocular muscles, are the unsuspected cause of much suffering. Too often in the diagnosis of such cases the ocular cause of the trouble is neglected, or thought of ultimately as a last expedient, when frequently it should have been considered and remedied first.

The symptoms of small refractive errors

Ranging from a mild degree of headache to symptoms simulating grave organic nervous disease, they are more complex and less easily detected, more common in their incidence and more prolific in unfortunate results. It is these in their various forms which are usually referred to as "eye-strain".

Referred Symptoms

No case of obscure headache should be treated on general medical lines without first eliminating the possibility of eye-strain as being one at least of the factors in its aetiology.

A condition of eye-strain has also a tendency to reflect on the general health and mental well-being.

It is true that eye-strain may cause much worry and unhappiness and it is certainly the case that it may lower the general vitality considerably.

The American authority, Dr. Edward Jackson, in Conrad Berens' "The Eye and its Diseases" (by 82 International authorities) states:—

Later in school life, the symptoms of eye-strain are persistent inattention, headaches, frequent congestion of the conjunctiva and eyelids, nausea, undue fatigue in the latter part of the day, anaemia and lowered physical resistance. These symptoms are most frequently due to hyperopia and can only be relieved by discovery and correction of the cause.

In adult life. . . . Hyperopia may be a cause of neurasthenia, melancholia, lowered nutrition, anaemia and chronic ill-health, without the more direct, obvious symptoms of eye-strain.

Vertigo, dizziness, nausea, vomiting, car-sickness, may all be caused by eye-strain, either ametropic or of motor inco-ordination.

Although S. Weir Mitchell, sixty years ago recognized the connection of errors of refraction with headache, nausea and other symptoms of disorder of the nervous system, the essential organic character of this connection is still not appreciated. The long list of such symptoms cannot be fully enumerated here. The essential thing to bear in mind is that any of them may be produced by eye-strain and only removal of the cause, by correcting every error of refraction, will give complete or permanent relief. This brings into the symptomatology of refractive errors most of the general symptoms of disordered nerve action or impaired nutrition.

Now we will consider for a moment—

PREVALENCE OF EYESTRAIN IN INDUSTRY

Excerpts from "Health and Unemployment—Some Studies of Their Relationships" by Leonard C. Marsh, Director of Social Research, McGill University.

Vision and other Eye Defects.—The Adult Sample Examined.

"The unemployed men as a group were revealed as definitely under a handicap in this respect—That no less than 87 per cent of the unemployed who were in need of glasses did not have them is a striking figure; but as the percentage among the employed men (53-2) shows, the general rate in this matter is itself high."

The Juvenile Sample Examined—Vision.

"Apparently there are few disabilities which the individual neglects, ignores, or considers to be of less consequence than defective vision. In days of prosperity, among all sorts and conditions of people, a certain reluctance is shown to the wearing of glasses. None are more prone to neglect eyesight than juveniles and adolescents, unless they are in receipt of proper advice."

"But the cost of eye examinations and the securing of glasses is of course the heaviest deterrent factor among the unemployed and those struggling to keep from going on relief. In the sample group examined, 30 per cent of the boys had defective vision."

"But the significant figure is that nearly 70 per cent of these cases were unremedied, i.e., only 30 per cent of those who needed glasses had them."

In Great Britain, ophthalmic benefit was included with dental benefit under "Additional Benefits," and refracting opticians were given a place on the panel and granted an examination fee of five shillings (\$1.25). This proved to be one of the most popular benefits.

We quote from Sir William Beveridge's Report:—

ADDITIONAL BENEFITS

Para. 56. "At the fifth valuation relating approximately to 1938, additional benefits were made available in societies with about 88 per cent of all insured men and 81 per cent of all the insured women; that is to say, only 12 per cent of the men and 19 per cent of the women had no more than the statutory benefit."

Para. 57. "The surpluses were very substantial in amount, as well as in the numbers covered. The annual allocation in schemes adopted on the fifth valuation amounted to £5,850,000 as compared with a total expenditure on benefit of all kinds, including additional benefits of about £35,000,000. The distribution of the total of £5,850,000 between different purposes is shown in the following table.

TABLE III

NATIONAL HEALTH INSURANCE—ANNUAL ALLOCATION FOR ADDITIONAL BENEFITS
(5th Valuation Schemes)

	Annual Allocation	Percentage of Total Allocation
Dental	£2,420,000	41·4
Ophthalmic	630,000	10·8
Medical and surgical appliances.....	200,000	3·4
Convalescent home treatment.....	160,000	2·7
Hospital treatment	90,000	1·5
Other treatment	150,000	2·6
		etc."

Para. 62. "An overwhelmingly large proportion of the valuation surpluses devoted to treatment benefits in the past has been allocated for the provision of dental and ophthalmic treatment, showing a need for these services which led all the associations of approved societies which gave evidence to the present committee to recommend that these particular forms of treatment should be made available for all insured persons."

Para. 63. "Eighty-five per cent of the very substantial annual sum (about £5,850,000) allocated for additional benefits on the last valuation was devoted to the provision of benefits—sickness, disablement, dental and ophthalmic—which in the opinion of practically everyone who gave evidence to the committee, ought now to be made statutory and universal."

Para. 435. "Dental and ophthalmic treatment and appliances are now overwhelmingly the most popular of the additional treatment benefits under national health insurance. That is to say, they are being paid for in part by compulsory contributions and for the rest mainly by a charge when treatment is given. There is a general demand that these services should become statutory benefits available to all under health insurance."

We trust we have convinced you gentlemen of the importance of our work and the necessity of including optometry in any national health insurance plan which you may formulate and we offer the following general suggestions as a plan for visual welfare under a social welfare scheme.

We believe that under a social security and health insurance plan all citizens should have like benefits of optometrical care.

Eye Examinations should be available to all citizens on a basis that—

- (a) All school children up to and including Grade 8 should be examined by optometrists or medical refractionists once a year. A method of doing such examining, of accurate "Screening Out" of the normal, and of recording from year to year the findings, is available. It is a matter of grave concern to Optometry that the number of myopic (short-sight) cases, according to authoritative figures, increases 600 per cent between the first and eighth grade. This results in boys and girls dropping out of outdoor games with detriment to their physical and social development, and in a national crisis a tremendous number of men are rejected from military service because of low visual acuity.
- (b) All adults and high school children should have access to thorough visual care either from an optometrist or medical refractionist. It is established that many cases of premature senility and blindness are due to lack of proper visual care.
- (c) Individuals should be permitted to choose their own practitioner.
- (d) There should be no interference with optometry as regards professional and ethical development.
- (e) The need for optometrical services should be determined by optometry.
- (f) Every optometrical licentiate to be eligible to participate in the plan.
- (g) An optometrist should be in charge of any plan involving visual problems or care.

We would urge that the draft bill be amended somewhat as follows to take care of these suggestions—

DRAFT BILL

Establishment of National Health Insurance and Personnel Thereof

16. (1) The word "Optometrical" be included so as to read in part:— and such other persons comprising a representative of the Canadian Medical Association, the Canadian Hospital Council, the Pharmaceutical, Nursing, Dental

and Optometrical professions, etc., and under First Schedule (Section 3)—it is important that provision be made for the establishment of eye refraction clinics, as well as eye clinics. This is especially necessary in the larger cities and localities, where there is a greater concentration of population. In New York and Philadelphia, it has become necessary because of the great increase of case load per doctor's hour, to refer all pathological cases to medical eye clinics and establish separate and distinct refraction clinics. This is quite in accord with the conclusions reached in the report of the American committee on the cost of medical care when it was recommended that eye care could only be achieved through the co-operation of the ophthalmologist and the optometrist and a division of labour between them. A periodic eye examination should be part and parcel of the program to be inaugurated.

BENEFITS

Kinds of Benefits.—Optometrical benefit be included and that a separate section be set up under the heading "Optometrical Benefit" similar to those already included.

ADMISSION OF COMMISSION

Other members how determined for appointment.—35. (4) To include organizations representative of optometrists.

REPRESENTATIVE COMMITTEES

45. (4) Shall also include the optometrical profession.

THIRD SCHEDULE

(Section 5)

A subsection be included to provide adequate visual inspection for school children both in urban and rural areas and for the adoption of corrective measures through co-operation with the health insurance authority.

And a similar subsection to provide for similar inspection of workers in industrial plants.

These might well take the form of a screening test similar to the Emmett A. Betts Series now being carried on in some schools and industrial concerns—

"Where there is no vision the people perish."

MEMORANDUM OF THE COLLEGE OF OPTOMETRISTS AND OPTICIANS OF THE PROVINCE OF QUEBEC AND OF THE SCHOOL OF OPTOMETRY AFFILIATED TO THE UNIVERSITY OF MONTREAL.

FOR THE SPECIAL COMMITTEE ON SOCIAL SECURITY

Mr. CHAIRMAN: I wish to thank you and the members of the committee for giving us an opportunity of submitting our views and of explaining in a few words what optometry consists in, what the College of Optometrists and Opticians of the province of Quebec is and the part which optometrists can and should play in a program of sickness insurance which is now being studied. I readily believe that all the members of the committee know what optometry is but it seems to me that a clear definition of this profession is needed for purposes of this discussion.

WHAT OPTOMETRY IS

The legal definition of the profession as mentioned in Article 17 of Chapter 274 of the revised statutes of the province of Quebec, 1941, is as follows:—

The employment of any means other than the use of drugs for the detecting and the measurement of errors of refraction such as hypermetropia, myopia, presbyopia, astigmatism and asthenopia by the adaptation of ophthalmic glasses for the aid thereof. It also includes any examination of the sight by any means whatsoever other than the use of drugs for determining, correcting or improving acuteness of vision.

We define this profession scientifically by stating that optometry is the science and art of examining the eyes, their functions, and of employing the preventive or corrective means which will assure the maximum of vision and comfort. These means are muscular exercises and proper ophthalmic glasses. The optometrist's role consists in correcting the defects which result from improper conformation of the ocular globe as well as ophthalmo-muscular deficiency. A university degree recognized by a provincial statute qualifies him and authorizes him to examine eyes and to seek, measure and correct abnormalities of eyesight. The optometrist is also able and qualified to detect any ophthalmic disease, to bring back defective acuteness of vision by following scientific data, and even to help and relieve muscular insufficiency by corrective exercise of the eyes.

In brief, the professional duties of the optometrist are to examine the eyes in order to, (a) detect errors of refraction, (b) ascertain defects in focusing and convergence, (c) detect pathological cases. To correct abnormalities of the eye he prescribes and furnishes ophthalmic glasses or collaborates with the ophthalmologist by referring to him real or suspected pathological cases.

Studies for the degree of bachelor of optometry last three years. They can be undertaken only after presenting to the university authorities (faculty of science section) a certificate in rhetoric, of second year arts (college) or their equivalent as determined by the matriculation bureau of the University of Montreal. These studies deal with the following subjects: philosophy, biology, drawing, chemistry, mathematics, physics, the physics of optics, the geometry of optics, theory of corrective glasses, laboratory instruments, optical physiology, theoretical optometry, refractive instruments, skiascopy, ocular refraction, general anatomy, ocular anatomy, physiology and pathology, myology, hygiene, clinical and ophthalmological dissection, glasses, optometric clinics, orthoptics and deontology.

In order not to take up uselessly the precious time of this committee, may I be permitted to leave with you, with this memorandum, a prospectus of the school of optometry in which we may see at pages 8, 9, 10, 11 and 12 a short summary of the course given by the professors on the subjects above mentioned.

General Anatomy.—General anatomy, anomalies and defects of conformation are fully discussed in their relation with the subject. Embryological cases showing some interest are explained if need be. Lectures are supplemented with diagrams, models and drawings on the blackboard.

Ocular Anatomy.—As ocular anatomy is the starting point of all ophthalmological studies, particular attention and considerable time are devoted to this subject.

Physiology.—The professor strives to give to the students a general and complete knowledge of ocular physiology. Studies in physiology are, as much as possible, the corollary of those in anatomy. While the students are studying the conformation of the eye, they also study the functions of that organ.

Pathology.—During the first year, the students are given a series of lectures on the elementary notions of ocular pathology, definitions and divisions of pathology, causes of diseases, lesions, inflammations, infections, immunity, tumors and evolution of diseases.

Optical mechanics (re frames and mountings).—The professor explains, in a few lessons, the composition of the spectacles, their different parts and their utility.

Skiascopy.—In the second year, students receive a certain number of explanatory lectures on the theory of shadows, and on the objective method employed to determine errors of refraction.

Instrumentation (Laboratory).—This course consists of a certain number of theoretical lectures on the different instruments of the laboratory; it is supplemented by practical demonstrations given by the professor or his assistant.

Ophthalmic lenses.—This course covers a general study of ophthalmic lenses used in optometry. The students examine the different kinds of lenses, their chemical composition, their scientific properties and their use in optometry.

Physical optics.—The professor strives to impart to the students a general and complete knowledge of this division of physics having for object the study of the phenomenon of light.

Geometrical optics.—The first term treats of the phenomena of optics: light, reflection, refraction, absorption and dispersion.

Theoretical optometry.—This course will cover the study of vision, of physiology of the vision, dioptric system of the eye and its functioning. These lectures are given with explanatory drawings.

Instrumentation (Refraction).—This course introduces the different scientific instruments employed in the diagnosis of errors of refraction and anomalies of the eye. The professor explains the mechanism and the use of these instruments.

Physiological optics.—This course comprises a serious and complete study of the optical construction of the eye and of its physiological functions.

Ocular Myology.—This course comprises a complete study of the ocular motive apparatus. It also treats of the correction of the different anomalies of the muscular system of the eye.

History of Optometry.—This course will consist of a few lectures, and will review the situation of the optician and the optometrist in the different civilizations of the middle ages and in modern times. Particular attention is given to the history of optometry in the province of Quebec.

Deontology and Optometrical Jurisprudence.—A few practical and interesting lectures will be given on these subjects. The lecturer will treat of the professional and ethical duties of the optometrist, of his responsibility and privileges, in connection with custom and law. Considerations on the laws of optometry.

Ocular Refraction.—Under the supervision of the professor, the students examine the refraction of the eye. The error of refraction must be determined and the correct prescription written.

Clinic.—Clinical Teaching being the final objective of all the scientific training of the students, this subject will be carried as far as possible, by utilizing all the resources at the disposal of the school. A modern clinic, where patients are examined, facilitates the work of the students.

Neutralization and Decentration.—This course, essentially practical, is given to second year students. It comprises a complete study of neutralization and decentration of the different ophthalmic lenses employed in optometry. This course is supplemented by explanatory demonstrations given by the professor.

Lense Surfacing.—This course consists in laboratory work and includes the handling of all material used in prothesis, the knowledge and mode of use of the

different materials necessary for the surfacing of optical lenses. Students are required to perform a series of optical work. They have at their disposal a perfectly equipped laboratory.

Laboratory.—In this course the student will put into practice the theory he has been taught, by making and adjusting spectacles required by the patients of the clinic. Every student is required to do a certain amount of fitting and this work is done under the immediate supervision of the professor.

Hygiene.—This course not only introduces the study of prophylaxy, but also the proper ways to insure the maximum good functioning of the human organism. So comprehended, hygiene has physiology as a basis, and is the practical application of its principles.

Myology.—The teaching of this subject treats of the anatomy of the different muscles of the eyes.

Dissection.—Dissection, which will be taught in second year, will serve as demonstration to the course of theoretical anatomy. Every lesson on dissection is preceded by a demonstration given by the professor on the region to be dissected.

TEACHING STAFF

Optometry.—Alphonse Phaneuf, O.D., titular professor.

Optics.—Lorenzo Favreau, O.D., titular professor.

Physiological Optics and Theoretical Optometry.—J. Armand Mésier O.D., titular professor.

Physical and Geometrical Optics.—E. Henri Coté, O.D., titular professor.

Ocular Anatomy, Pathology, Physiology and Hygiene.—Georges Monfette, M.D., professor.

Philosophy.—Augustin Bédard, P.S.S., D.Th., D.Ph., professor.

Biology.—Gérard Gardner, L. ès S.N., professor.

Physics.—Joseph Demers, B. A., L. ès S.N., professor.

Mathematics.—Abel Gauthier, L. ès S. Ph., professor.

Drawing.—Joseph St-Charles, professor.

Chemistry.—Lionel Lemay, M.Sc., professor.

History of Optometry, Optometrical Deontology and Jurisprudence.—E.-Henri Coté, professor.

CLINICIANS

Clinic of Optometry.—Alphonse Phaneuf, O.D., J. Armand Messier, O.D.

Clinic of Ophthalmology.—Georges Monfette, M.D.

Laboratory.—Lorenzo Favreau, O.D., E.-Henri Coté, O.D.

Myology and Orthoptics.—J.-Armand Messier, O.D.

EMERITUS PROFESSOR

Optometry and Optics.—Alfred Mignot, O.D.

FORMER PROFESSORS

Rodrique Carrière, deceased in 1934; Maurice de Meslé, deceased in 1934;

Ernest Foucher, M.D.; Lucien Gélinas, M.D.; A. L. Guertin, M.D.;

Alfred Mignot, O.D.; Patrick Mount, O.D., deceased in 1914; Jean L.

Rochon, B.O.; W. H. Walsh, O.D., deceased in 1929.

This will allow me to state definitely that the optometrist is absolutely qualified and renders services to the community. Moreover, optometry has been officially recognized in this province by a statute which dates from 1904, that is, for the past 39 years.

WHAT THE COLLEGE OF OPTOMETRISTS AND OPTICIANS OF THE PROVINCE OF
QUEBEC IS

Founded in 1910 the College of Optometrists and Opticians of the Province of Quebec is of perpetual succession and has all the powers conferred upon civil corporation by the laws of the province. It is composed of all optometrists, without exception, who practise their profession in the province or all who, in future, will have followed the course and passed successfully the examinations required by law; there are now 265 members in active practice.

No one is authorized to practise optometry in the province of Quebec unless such person has obtained his bachelor's degree in optometry and has moreover secured a licence from the Council of the College of Optometrists and Opticians of the province of Quebec (Article 18 of the Statutes previously cited).

As a result the chairman and his eight elected governors are possessed of the required authority to speak in the name of the optometrists of Quebec.

In the same way as the College of Physicians and Surgeons and the College of Surgeon Dentists of the Province of Quebec, our college has absolute control over the practising members and in addition sees that the provincial law, which enacts that no one may practise optometry without a licence, is observed. An exception is made however for doctors duly authorized to practise medicine under the laws of this province. (Article 47 of Chapter 274 of the revised statutes of Quebec, 1941.)

It results from this exception that two professional bodies in the province of Quebec are authorized, in virtue of a special statute, to examine eyesight and prescribe glasses to correct abnormalities of eyesight.

Nevertheless, in the preamble to the sickness-insurance act there is no mention made of the optometrist. Therefore, it follows that there would be discrimination if one professional body were allowed to practise optometry within the scope of the sickness-insurance plan while another were refused this right. Moreover, in view of the exceedingly restricted number of doctors who have become specialized in this branch of work, it would be impossible for them to handle all the work.

THE OPTOMETRIST'S PART IN A PLAN OF SICKNESS INSURANCE

All recognize that the pupil, workman, manufacturer and professional man needs to see well with both eyes in order to do their work properly. And, semi-official statistics show that a very great proportion of the people are obliged to submit, at different intervals, varying between six months and three years, to examination of their sight either to verify the state of their vision or to make some change in their corrective methods.

In the province of Quebec this work is done by 265 optometrists and a certain number of specialized doctors known as oculists or ophthalmologists.

As a great portion of the public consults an optometrist for examination of eyesight it seems only just that one specially trained in this profession should be given the right to practice his profession for the benefit of the great majority which has entrusted itself to his care for the past 39 years, in any sickness-insurance plan.

We have not thoroughly studied the incidental aspect of the profession, that of glasses, and we have no recommendation to make in this regard now. The reason for this is that, in the draft of the sickness-insurance act, it is alleged that an assessment of \$26.00 a year is not sufficient to cover all the dental care of adults or children. It seems, therefore, at first sight, that if the assess-

ments are not high enough to cover dental costs they are even more insufficient to cover cost of glasses. However Dr. P. C. Routley general secretary of the Canadian Medical Association has suggested in his memorandum presented here on April 6th last, (and I am citing his text taken from the evidence and minutes of this day on page 146, section G, to the effect that) "All accessories, such as *glasses*, crutches, artificial limbs, etc., should be available when such are reasonably requested or authorized."

However, if your committee consider it advisable to study this point more thoroughly I can assure it in advance of the full collaboration of the College of Optometrists and Opticians of the province of Quebec as well as of the School of Optometry which I have the honour to represent today.

For the moment, seeing that the sickness-insurance bill does not include furnishing of glasses to the insured I will make recommendations only insofar as the examination of eyesight is concerned.

The college and school above-mentioned suggest through my intermediary:

1. That optometrists be represented, provincially as well as federally, on the committees or commissions which will operate the sickness-insurance act;

2. That examination of the acuteness of vision of children attending schools be compulsory;

3. That, in the work of ascertaining defects in sight, the service of optometrists be retained;

4. That clinics be established in various centres of the province for the examination of the sight and the furnishing of glasses, free of charge, to children whose parents do not earn enough to pay the assessment required under the Act;

5. That insured persons be left free to choose an optometrist or a doctor-oculist, to have their eyes examined;

6. That every optometrist in the province of Quebec who is in good standing in our college be eligible to practise under the sickness-insurance plan;

7. That the fees allowed optometrists for examination of eyesight be established by a representative body of this profession in agreement with a committee of Department of National Health or of the Sickness-Insurance Commission.

In conclusion it must be admitted that, in a plan of sickness-insurance of the scope of that now being proposed, measures should be taken in order that the insured may entrust the examination of his eyesight to either the optometrist or the doctor specialized in such work.

The whole respectfully submitted on behalf of the College of Optometrists and Opticians of the Province of Quebec and of the School of Optometry affiliated with the University of Montreal, by J. H. Lionel Hébert, secretary of the said College of Optometrists and Opticians of the Province of Quebec.

The CHAIRMAN: Are there any questions?

Mr. COTE: I understand, Mr. Chairman, that Mr. McClung, the president of the Canadian Association of Optometrists, mentioned that the Canadian Association had prepared a brief which has not been presented to the committee. I suppose that this brief is a little too long to be presented at this time.

The CHAIRMAN: I have it here. I stated it would be placed on the record. Are there any comments on it, Mr. McClung?

Mr. McCLUNG: That brief was prepared by Mr. Bind, our secretary, who resides in Toronto and is very closely in contact with Ottawa, much more so than myself away out in Regina. The onus of this whole matter has mostly fallen on him. He has been dealing with the department and with Dr. Heagerty

and he has prepared this brief. We would have liked to have had time to present it word by word and have it discussed but we will do whatever is your pleasure in the matter. Mr. Bind's copy is recognized as the brief from the Canadian Association.

The CHAIRMAN: Is there any part of this brief, Mr. McClung, that you care to emphasize particularly?

Mr. McCLUNG: I will speak to Mr. Bind.

The CHAIRMAN: Will Mr. Bind be available for the committee later if they wish to consult him?

Mr. E. BIND: I will be very glad to be.

Mr. McCLUNG: He is in Toronto and I am sure he could come up at short notice any time to confer with the committee.

The CHAIRMAN: Thank you. Mr. Bind, is there something that you would care to stress?

Mr. BIND: I would like to point out that I have taken your own witnesses in this brief. I have taken some excerpts from the report of Dr. Marsh and I have also taken excerpts from Sir William Beveridge's report. I would like to point out that the ophthalmic benefit, which is stated as an additional benefit in the English Act, amounts to a considerable sum. It amounts annually to some £630,000 which was for examination fees alone without the addition of glasses on top. I would be also like to point out here an excerpt taken from Sir William Beveridge's report:—

“An over-whelmingly large proportion of the valuation surpluses devoted to treatment benefits in the past has been allocated for the provision of dental and ophthalmic treatment, showing a need for these services which led all the associations of approved societies which gave evidence to the present committee to recommend that these particular forms of treatment should be made available to all insured persons.”

That is accentuated in two or three paragraphs which I have quoted there. Then we also set out some sort of plan which could be used. We have also taken the draft bill and have inserted words where we think it is necessary. We would not wish the bill to go through as it is without some mention of ophthalmic benefits or optometry.

The CHAIRMAN: On page 6 you make certain suggestions with regard to changes in the bill?

Mr. BIND: Yes.

Mr. COTE: Mr. Chairman, I would like to know from Mr. Hebert whether in the province of Quebec optometrists are accepted as such in the public hospitals and to what extent they do give their care to hospital patients?

The WITNESS: In the province of Quebec the optometrists are doing refraction work in five hospitals which include Notre Dame, St. Jude, St. Jean d'Arc, Verdun Hospital and Hotel Dieu.

Mr. BLANCHETTE: Are they all in the city of Montreal?

The WITNESS: Yes, they are all in Montreal.

The CHAIRMAN: Are there any further questions.

Mr. ROEBUCK: I would like to know from Mr. Hébert whether the word “optometry” under section 27—have you the proposed act before you? Take the section in which Dr. McCann referred (section 27); Dr. McCann said there was no need to worry because subsection 3 of section 27 says:—

“(3) Benefits referred to in the last preceding subsection shall include such special and technical procedure and ancillary services as

may be prescribed and as may, in accordance with regulations made hereunder, be deemed necessary to make effective the said benefits in the case of any qualified person."

Subsection 2 of the same section reads:

"(2) For the purposes of this act the benefits referred to in the last preceding subsection shall be administered under the following heads, namely

- (a) Medical, surgical and obstetrical benefits.
- (b) Dental benefit.
- (c) Pharmaceutical benefit.
- (d) Hospital benefit.
- (e) Nursing benefit."

That is to say, a person who desires dental or pharmaceutical appliances may have it at the discretion of the chairman of the board, but if he wishes to have optometric benefits, which is an ancillary service, he must go to the doctor and have optometry prescribed. That is the way I understand the bill. Now, would it satisfy the optometrists if after "(e) Nursing benefit."; or somewhere in the order of this list, you had "(f) Optometry benefits"; putting it on the same basis as medical, surgical and obstetrical benefits, dental benefit, pharmaceutical benefit, hospital benefit and nursing benefit.

The WITNESS: That would satisfy us.

Mr. BIND: May I point out in that connection that there are certain places further along where the word optometry would have to be included to bring the bill in line with the change Mr. Roebuck has just suggested.

Mr. CORÉ: I would like to ask a question of Mr. McClung: we were told that there were not a sufficient number of ophthalmologists in Canada to attend adequately to the probable demand for refraction examinations; I would like to know to what extent are the optometrists necessary in viewness of the scarcity of these specialized doctors; also, what their relationship is with the ophthalmologists, the eye specialists, how to they get along together?

Mr. MCCLUNG: You ask first about that proportion of people who patronize optometrists (to put it briefly) as compared with other branches of refraction. I believe that the Public Vision Institute, that is a non-commercial institute down in the States, has compiled these figures, they show that about 70 per cent of those requiring optical attention patronize optometrists.

And now, the next part of your question was in regard to co-operation that we can expect with the medical profession. I am very glad to say that I get along very harmoniously with most of our medical refraction friends. In fact, when I came away from home to come down here I asked a medical refractionist, Dr. McMurtry, to care for my emergency work, and he is doing so. I know that in a great many parts of the country we are pleased to report that the medical profession, the general practitioner, recognizes optometry as a very capable branch of science to whom to refer patients but unfortunately as in most professions there are those in both optometry and medicine who are extremely biased in favour of their own profession. We would like to feel in the wording of this Act that we are not subject to the domination of such a class of men, not the general practitioner, but those who like some of ourselves are too strongly biased against us.

Mr. CORÉ: At the school of optometry, which has jurisdiction in the University of Montreal, would you tell us what assistance you have had from the ophthalmologist or the medical men in the training of the optometrists to be.

Mr. HEBERT: The man who teaches ophthalmology at the school of optometry in Montreal is Dr. Monfette, the chief of the department of ophthalmology. He teaches anatomy, physiology, ocular pathology and otology.

Mr. COTÉ: Has the medical profession co-operated with you in the training of your students for some time?

Mr. HEBERT: For the last thirty-five years.

Mr. ROEBUCK: I should like the same statement from Mr. Fisher of Ontario. He is one of the staff of the Ontario college.

Mr. FISHER: We get along fairly well with our Montreal friends. We have a doctor on the staff who teaches neurology and we also have the utmost co-operation with the University of Toronto in the anatomy department and the physiology department and the doctors there who instruct our students.

Mr. J. G. FOGO: May I be permitted to say that the board of examiners of optometry from Nova Scotia wish to be associated with the statements made here today.

The CHAIRMAN: On behalf of the committee I should like to thank the optometrists for their statements here today.

Mr. COTÉ: Mr. W. J. Maxwell, the secretary of the New Brunswick optometry association, is here and he also represents Nova Scotia and Prince Edward Island associations. Then there is Mr. F. Nuttall, secretary-treasurer of the Alberta association, Mr. D. A. Maguire, from the Manitoba association of optometrists, and Mr. A. Mignot, vice-president of the Canadian Association of Optometrists and also president of the college of optometrists, and they all support the views which have been presented this morning in these briefs.

Mr. HEBERT: I have nothing to add except that we feel we are leaving our case in good hands, and we are looking for more protection as every province in Canada recognizes our ability. We are gaining ground in the confidence of the legislatures every year, and every province in Canada supports optometry within its boundaries. Therefore, we are very glad to leave the matter in your hands. Every province in Canada has optometry on its statutes. With regard to the question asked by Mr. Côté whether there were optometrists doing optometry work in hospitals, I may say that optometry is practised in five hospitals in Montreal, namely, Notre Dame, St. Jean d'Arc, Verdun, St. Luke and Hotel-Dieu.

The CHAIRMAN: We thank you all gentlemen for your presentations here today, and we will adjourn to meet again on Friday.

The committee adjourned to meet Friday, June 4, at 11 a.m.

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SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 17

FRIDAY, JUNE 4, 1943

WITNESSES:

- Mr. John S. Burton, Secretary and Counsel for the Dominion Council of Chiropractors;
- Dr. Walter Sturdy, Vancouver, President, Dominion Council of Chiropractors;
- Dr. J. S. Clubine, Secretary-Treasurer, Dominion Council of Chiropractors;
- Dr. A. W. Macfie, Secretary-Treasurer, Board of Regents of Ontario for Drugless Practitioners;
- Dr. Detweler, President, Board of Regents of Ontario, for Drugless Practitioners.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

FRIDAY, June 4, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. Hon. Cyrus Macmillan, the chairman, presided.

The following members were present: Messrs. Adamson, Bruce, Casselman (Mrs.) (*Edmonton East*), Cleaver, Donnelly, Fauteux, Fulford, Gershaw, Hatfield, Hurtubise, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, Mayhew, Picard, Veniot, and Warren—23.

The chairman read a telegram from the Alumni Association of the College of Optometry of Ontario approving of the brief submitted by the Board of Examiners in Optometry. This was signed by W. H. Landon, secretary.

A statement showing additional information on venereal diseases submitted by Dr. Gordon Bates, director, Health League of Canada, was ordered to be printed as Appendix "A" to this day's evidence.

A brief from the Human Adjustment Institute, forwarded through Mr. MacInnis, M.P., was submitted to the committee and ordered printed as Appendix "B" to this day's evidence.

Mr. Mayhew suggested that the committee suspend the hearing of witnesses to consider the question of old age pensions. The chairman requested that this be deferred as arrangements had already been made to hear witnesses. To this Mr. Mayhew agreed.

Mr. Roebuck, M.P., expressed the wish to ask for an appointment to hear witnesses. He was informed that this should be dealt with by the agenda committee.

Mr. John S. Burton, Secretary and Counsel for the Dominion Council of Chiropractors, was called. He introduced:—

Dr. Walter Sturdy, Vancouver, President of the Canadian Chiropractors Association.

Dr. J. A. Schnick, Hamilton, Vice-President, Canadian Chiropractors Association.

Dr. J. S. Clubine, Toronto, Secretary-Treasurer, Canadian Chiropractors Association.

Mr. Burton then presented a brief and was examined by the committee.

Doctors Sturdy and Clubine were also called and examined.

The witnesses retired.

Attention was called to an error in the evidence given by Dr. J. J. Heagerty on March 30, page 118, line 21, where "auxiliary services" should read "ancillary services".

Dr. A. W. Macfie, Secretary-Treasurer of the Board of Regents administering the Drugless Practitioners Act for Ontario, was called.

He introduced the president of that organization.

Dr. Detweler, who presented a brief, was examined, and retired.

The chairman thanked all the witnesses who had given evidence to-day.

The committee adjourned at 1.00 o'clock, p.m., to meet again Tuesday, June 8, at 11.00, a.m.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 4, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Before we proceed with the witnesses to-day, with your permission I should like to put two or three documents on the record. The first is a telegram, which reads as follows:—

The executive of the Alumni Association of the College of Optometry of Ontario, representing graduates of this college throughout the dominion, respectfully recommends for your earnest consideration the brief as submitted by the Board of Examiners in Optometry, province of Ontario.

W. H. LANDON,

Secretary.

In other words they express their approval of the brief.

There is some additional information concerning venereal diseases in an educational programme submitted by Dr. Bates, which was not available when he presented his brief. It is an interesting document on statistics and with your permission it will go in the record. (Appendix "A".)

There is also a brief from the Human Adjustment Institute of Vancouver. It is a very interesting brief, forwarded to Mr. MacInnis, a member of the committee, for presentation. Is it your wish that this brief should go on the record as being read, Mr. MacInnis?

Mr. MACINNIS: Yes. (Appendix "B".)

The CHAIRMAN: Mr. Mayhew, have you a statement to make?

Mr. MAYHEW: Mr. Chairman, I should like to make a suggestion at this point to the committee, but before making the suggestion I should like to assure the committee it is not with any idea of holding up the proceedings or in any way limiting the number of witnesses who are called. So far I believe we have brought together a lot of information which is not only exceedingly useful for the study which we are engaged in, but also for future references. I am sure the general procedure of the committee is appreciated by all and I think those of us who have read the editorial in the *New York Times* last Friday realize that our procedure is appreciated by that organ at least. However, we have in our communities in Canada quite a large number of old people who at the present time, in my opinion, have not sufficient on which to get along. Many of them are in very straitened circumstances and I believe it would be possible and right if we could suspend some of the headings and deal with old age pensioners, to find out whether they are getting an adequate amount or not. I think this comes within the order of our reference, Mr. Chairman, and I should like it to get some consideration.

The CHAIRMAN: Thank you. I am not sure that it comes within the order of reference, but I think perhaps it might be included in the last phrase of the reference, "and other related matters". That is your understanding, is it?

Mr. MAYHEW: Yes.

The CHAIRMAN: "—constitutional and financial adjustments which will be required for the achievement of a nation-wide plan for social security; and other related matters."

Mr. MAYHEW: Yes.

The CHAIRMAN: I think that is a fair interpretation. The difficulty is this: we have made commitments with organizations and with individuals to hear them as soon as possible. They have been notified of the date when they will be expected to appear and I think the committee would appreciate it if you could defer discussion of this question until after these commitments have been honoured.

Mr. MAYHEW: I will accept the answer, Mr. Chairman.

Mr. ROEBUCK: Mr. Chairman—

The CHAIRMAN: Order, please. Is it the wish of the committee to hear Mr. Roebuck, who is not a member of the committee?

Mr. MACINNIS: I should like to know for what purpose he wants to speak.

The CHAIRMAN: What is the subject-matter of your discussion?

Mr. ROEBUCK: I want to ask about an appointment which I have asked for.

The CHAIRMAN: You can take that up with the secretary afterwards.

Mr. ROEBUCK: Is that the courtesy I receive from this committee?

Mr. MACINNIS: I think there is an agenda committee and all questions of that kind should be brought to that committee. If we are to hear Mr. Roebuck now we would have to hear anyone that came before us and it would certainly upset the agenda for the day, I think. I have no objection to hearing anyone who comes before this committee, but it should be arranged beforehand.

The CHAIRMAN: My suggestion is that it be referred to the secretary who will refer it to the agenda committee.

Mr. ROEBUCK: I have already written to you three times and I have not had a reply.

The CHAIRMAN: I thought you discussed it with the secretary.

Mr. ROEBUCK: I have written to you three times and you have not given me a definite reply. I take it you do not wish to hear the organization.

The CHAIRMAN: That is quite a wrong interpretation. We have not refused any organization or any individual who represents a reputable organization. We have made commitments, as I said some time ago, and as soon as those commitments are honoured then we shall try to hear as many others as we possibly can. That is the best we can do in the circumstances. At the moment we cannot give a definite date for hearing anybody until the 15th of June. It is not possible because of the appointments we have made.

Mr. ROEBUCK: You might have given me that answer by letter.

Mr. CLEAVER: I think we perhaps could give an undertaking or advise these other societies or organizations who wish to be heard that before the work of the committee is completed anyone who is here representing a reputable organization will be granted a hearing. Certainly, if they are interested enough to come to Ottawa at their own expense and they wish to make a contribution to our work I think that we can hear them.

Now, with regard to the commitments which you have already made, I think they should be honoured and then these other organizations told when they will be heard.

The CHAIRMAN: Yes, that will be done.

Mr. ROEBUCK: It would not have hurt you, Mr. Chairman, to say that.

The CHAIRMAN: This morning we are to hear representatives of the Dominion Council of Chiropractors. Mr. Burton, the secretary, will introduce his colleagues and present the brief.

Mr. Burton, please.

Mr. JOHN S. BURTON, Counsel for Dominion Council of Canadian Chiropractors, called.

The WITNESS: Mr. Chairman, Mrs. Casselman, Hon. Mr. Mackenzie and members of the committee, first I should like to introduce to you Dr. Walter Sturdy, Vancouver, President of the Canadian Chiropractors Association, Dr. J. A. Schnick from Hamilton, who is vice-president of our association, and Dr. J. S. Clubine from Toronto, who is secretary-treasurer. It may be that during the course of questioning there will be technical questions asked and I ask the privilege, Mr. Chairman, of having these witnesses answer questions which I think lies peculiarly within their province.

On behalf of the Dominion Council of Canadian Chiropractors, I wish to express our appreciation of this opportunity to appear before this committee to present our brief. I appear as General Secretary and Counsel of this body which represents the chiropractors of Canada.

We believe in the principle of health insurance which, we take to mean in effect, that the people of Canada should receive the greatest possible health protection. Such an Act should be based on a sound foundation and equally protect those who administer to health needs as well as those who contribute and receive those benefits. Our submission is that the proposed health insurance act falls far short of this underlying principle in that it makes no provision for the recognition of chiropractic, or any health agency except orthodox medicine. We submit that chiropractic, being the second largest health profession in the world, is entitled to be placed on the same basis as orthodox medicine under the Act, so that the public of Canada may have the right to get well by the method of their choice. This is an elementary right to which we are all entitled and, as will appear in our presentation, Canadian citizens will demand, and are demanding, that right. We believe that the contributors will not be content to accept only those benefits set out but will insist on absolute freedom of choice of health practitioner.

In addition by providing that the chairman of the National Council and the provincial commissions shall be medical men and the only salaried members, and the preponderance of medical practitioners on the council and commissions, the Act virtually sets up a complete medical dictatorship and monopoly. We request, therefore, adequate representation on those bodies.

Our submissions can be grouped under the following heads:—

1. Chiropractic is an established and recognized health profession in Canada.

2. The education and training of chiropractors qualify them to treat the ailments, diseases, defects and disabilities of the people of Canada.

3. A large proportion of the population of Canada depend on chiropractic practice for their health needs.

4. The citizens of Canada demand the right to choose their own health practitioner.

5. Chiropractic has had unparalleled success in the treatment of diseases and in the percentage of recovery.

6. Chiropractic in itself is the best preventative medicine.

7. Chiropractic cannot be an "auxiliary service".

In order to properly understand and appreciate our position, it will be first necessary to briefly outline the position in which chiropractic is placed under the proposed Act as drafted and the philosophy and theory of chiropractic.

THE POSITION OF CHIROPRACTIC UNDER THE PROPOSED ACT

As you, of course, are quite aware the dominion Act as presented to this committee makes no provision on the National Council on Health Insurance for representation from the chiropractic profession. It is, in fact, as Mr. P. R. Bengough pointed out to you on May 18, 1943 (proceedings page 331) to be controlled by the medical profession and this is despite the widespread practice of chiropractic in Canada today. Similarly the health insurance commissions of the provinces are likewise designed to exclude provision for chiropractic representation. Provided they conform to certain standards, the nine provinces of Canada will be entitled to inaugurate health insurance, receive grants-in-aid from the dominion government, and administer the benefits as outlined in the draft presented to them by this government. While it may be possible for a province to extend the benefits to be given under the Act, nevertheless, since they are set out in detail in the draft provincial acts and provide for medical, surgical, dental, pharmaceutical, hospital, nursing and "such auxiliary services as may be prescribed" any extension may be difficult and, in point of fact, unwelcome to the national government. All evidence to date presented to this committee makes it perfectly clear that no provision is contemplated for chiropractic but, as has been stated by Dr. Heagerty, on March 30, 1943 (proceedings page 118), such services could be classified as "auxiliary". To this we, as the custodians of the health of a large part of the people of Canada, do most strongly object.

WHAT IS CHIROPRACTIC?

The science of chiropractic was developed in 1895 by the late Dr. D. D. Palmer who was born at Port Perry, some 50 miles from Toronto, Ontario. Dr. Palmer developed the science and in 1903 he founded the first chiropractic college in Davenport, Iowa.

Chiropractic is a system of healing based on the principle of cause and effect. Disease is always regarded as the end-product or effect of a series of changes that have occurred in the body following a primary cause. Chiropractors regard the human body in all its parts—in good health—as a perfectly balanced structural organism through which the innate intelligence or life forces operate, keeping all parts in harmony or health.

To substantiate this premise, let me quote from Gray's Anatomy, 26th Edition, 1935, at page 867, in the introductory paragraph on neurology: "The nervous system is the mechanism by which all, save the lowest, forms of animal life are enabled to react to their environment. In addition, the nervous system controls and regulates the activities of all the other systems of the body and determines their harmonious co-operation, for the benefit of the organism as a whole."

It is an anatomical fact that the brain, which lies within a marvelously protected bony box, the skull, is the primary centre of all this intelligence or life force; that the spinal cord which lies within the spinal column, is the continuation of the nervous mechanism downward, from the brain and thence to all parts of the body; that the spinal cord is a very intricate reflex chain of nerves and nerve connections (reflex centres, ganglia, associating with sympathetic and parasympathetic nervous systems, etc.) acting as a distributing and controlling centre of life forces from the brain to all parts of the body, either directly or indirectly,—thus the spinal cord is the great connecting link between the centre of intelligence, the brain, and the working parts of the body, whether organs, glands, muscles, secretions, etc.; that due to the fact that the spinal column is also the

main supporting shaft of all body structures, and at the same time performs the duty of chief distributing centre of the intelligent life forces from the brain to all parts of the body:—Therefore, the chiropractors believe the spinal column is the chief place where interference with the transmission of these all-essential life forces is likely to occur, especially where the spinal nerves make their exit through the spinal column on their way to the various parts of the body (there are 31 pairs of these nerves with about as many movable segments); that the spinal column, the supporting shaft of all body structures, has to (must) adjust itself to all the shocks, jars, strains, accidents, etc., whether major or minor, throughout the whole day, and every day of our lives, and that failing to make complete adjustment at all times to these various changes, what is known as subluxations or slight spinal displacements, occur, and many times remain; that if these subluxations are allowed to remain, become the true cause or primary cause of disease. This reasoning is clear since the slightest interference with the transmission of these delicate life forces or energy from brain to all parts of the body results in mal-function in the part or parts affected. Thus we have disease in the making, the final stages of which may be anything from common headache or common cold to cancer or tuberculosis.

The chiropractor gets people well by adjusting with his hands these spinal irregularities thus freeing the nerves to carry their normal load of life energy; nature begins at once to restore health. We regard any imbalanced relation between the structural parts of the body as a cause of disease, whether this disrelation be in the spinal column, or other supporting parts, such as the sacroiliac, shoulders, elbows, wrists, knees, ankles or feet.

The founder of chiropractic, Dr. D. D. Palmer, proved the truth of the chiropractic principle; he said: "I reasoned that the very apparent spinal subluxation in Mr. Lillard's spine may be the cause of deafness; I adjusted the vertebra into place and Mr. Lillard's hearing was restored".

Health comes from within, and where good health exists disease cannot enter. Here is where chiropractic is the greatest of all known preventive healing methods. It gets at the primary cause and the effects die of their own weight; they are starved to death for want of food, the wastes in the body.

In short, chiropractic restores people to health by adjusting structural parts to their normal position. They are then content to leave the rest to nature, the great healer. As the wise old doctor once said—"I dressed the wound, but God healed it." The chiropractic principle has proved itself millions of times in thousands of cases. No greater proof can be given than the fact that most of the people who avail themselves of our services have been failures under other orthodox methods. It is a victory of principle properly applied over less definite methods.

With this introduction we are now prepared to discuss the reasons why we believe chiropractic should be included under the national health insurance plan.

1. *The Position of Chiropractic in Canada to-day as an Established and Recognized Health Profession*

The Dominion Council of Canadian Chiropractors is composed of the elected representatives of the chiropractic associations of the provinces of Canada. Chiropractic is recognized by law in four provinces, namely, Ontario, Saskatchewan, Alberta, and British Columbia. Chiropractors in these provinces number 571 of a total of 668 in all Canada. Bear in mind that in the maritime provinces there are only fifteen practising chiropractors.

By Mr. McCann:

Q. Have they any legal status in those provinces?—A. No, they have not as yet.

Q. In what provinces have they no legal status?—A. The three maritime provinces, Quebec, and Manitoba.

Q. That is five out of nine where they are not recognized at all?—A. That is correct, but as I say in three of those provinces they only have fifteen chiropractors. Chiropractors in these provinces number 571 of a total of 668 in all Canada, or over five-sixths of the total. The legislatures of those provinces after the most careful scrutiny and after thorough examination by royal commissions, etc., passed Acts setting up the profession of chiropractic on the same basis as medicine in the treatment of the human body. Chiropractic boards control discipline of their members, admission of candidates, fees, and generally have complete supervision over the profession.

By provinces, the chiropractors actually practising at this moment in Canada number as follows:—

British Columbia.....	72
Alberta	39
Saskatchewan	43
Manitoba	47
Ontario	417
Quebec	35
Maritime Provinces.....	15
Total	668

This does not include 10 per cent to 15 per cent of this number now on active service.

By Mr. McCann:

Q. May I ask a question here, on active service in what capacity?—A. In the capacity of shouldering muskets. They are in the active combatant service.

Q. The inference was that they are on active service as chiropractors?—A. I do not think that is the right inference because I think perhaps it is well known that we have attempted to have chiropractors in their proper place in the army but so far we have not yet been successful.

It is worthy of note that Dr. Routley, general secretary of the Canadian Medical Association, giving evidence before this committee on April 6, 1943, (Proceedings page 134) said that there are registered in Canada approximately 10,600 doctors. In other words, there is one chiropractor in Canada to every fifteen medical men. In the United States there is one in ten in normal times, one chiropractor to every ten medical doctors across the whole breadth of the country. In some states it is down as low as one to three. I think that is California.

It may also be noted that wartime conditions have depleted Canada of a great number of medical doctors so that the ratio is now considerably changed. It has been stated that there are now only 7,000 doctors practising in Canada. I noticed in the press the other day that the Hon. Colonel Ralston pointed out there were some 3,115 medical doctors in the army in the medical corps.

This means there is one chiropractor to approximately every ten medical men, yet this bill as it stands gives to the medical profession the complete control over the health of all the people of Canada and gives no recognition whatsoever to the chiropractor.

The Encyclopaedia Britannica, 1943 edition, tells us that there are now some 18,000 chiropractors in the United States and Canada and that in the United States legal recognition is given in 42 of the 48 States, the District of Columbia, Alaska and Hawaii. There are now 44 States and one more is considering chiropractic legislation. Chiropractic is practised in practically every country in the world and has had a stupendous growth. The Russian army commissions chiropractors and I have been told by a prominent Russian

that he has in his possession Russian newspapers extolling the wonderful services performed by chiropractors in the Russian army in this war, including services as chiropractors in advanced dressing stations right on the field of battle.

We take the position, therefore, that chiropractic is a recognized and legalized profession of healing and as such it should be entitled to the same recognition as orthodox medicine and its benefits extended to the public under health insurance. It is not necessary to consider its relative merits or demerits as opposed to medicine. Each practises in its own field. It is no more competent for a medical doctor to pass his opinion on chiropractic than it is for a chiropractor to pass his opinion on medicine.

2. *The Educational Standards of Chiropractors*

The National Chiropractic Association has approved at least 12 chiropractic colleges in the United States. These colleges have established high educational requirements. In Canada, to be admitted to practise as a chiropractor, a candidate must have provincial junior matriculation standing, or its equivalent. He must be a graduate of a recognized chiropractic college and the standard set by the Dominion Council is a four-year course of at least eight months each. In Ontario, it is four years of nine months each. The chiropractic course given by colleges is extremely broad and includes all the basic subjects such as anatomy, bacteriology, diagnosis, etc., as well as the chiropractic subjects but the student is not taught, nor is he entitled to practise surgery, administer drugs, anaesthetics, or set fractures. The successful student must obtain high ranking in at least the following subjects:—

Anatomy (including all branches, gross anatomy, dissection, etc.)	Diagnosis
Physiology	Psychiatry
Chemistry	Gynecology
Medical jurisprudence	Bacteriology
Pathology	Hygiene and sanitation
Psychology	Symptomatology
Eye, ear, nose and throat	Obstetrics
Histology	Principles of practice
Dietetics	Technique and treatment in chiropractic

After graduation the student must then pass board examinations of the provinces in most, if not all, of these subjects and demonstrate his ability to practice the profession by practical tests and demonstrations. May I just pause here to point out that 40 years ago, if my information is correct, the medical college course was two years. It gradually went up. The chiropractic course has been going up steadily until it is now almost the same as medicine.

Our definition of a chiropractor, and I am quoting the Ontario Act, is as follows:—

Chiropractor shall mean any person who practises or advertises or holds himself out in any way as practising the treatment, by diagnosis (including all diagnostic methods), spinal analysis, direction, advice, written or otherwise, of any ailment, disease, defect or disability of the human body, by methods of adjustment by hand of one or more of the several articulations of the human body, more especially those of the spinal column, taught in colleges of chiropractic and approved by the board.

It, therefore, will readily be seen that before chiropractors are allowed to practise they are well equipped to treat the human body for ailment, disease, defect or disability. They are fully qualified to take complete charge

of the sick or injured and if they find that surgery is indicated, being educated in the fundamentals, they do not hesitate to refer these cases to the surgeon just as a medical man refers dental work to a dentist and specialized cases to a specialist.

3. *The Public Depends on Chiropractic*

The workmen's compensation acts of three provinces; namely, Ontario, Alberta and British Columbia recognize chiropractic and provide that injured workmen may avail themselves of the services of chiropractors, the compensation board paying the cost. In 1941 the honourable Mr. Justice Sloan of the Court of Appeal of British Columbia, as a royal commissioner, conducted an inquiry into the operation of the British Columbia Compensation Act. After months of evidence he recommended that the act be extended to provide for the services of chiropractors. Organized labour throughout the whole province of British Columbia presented a unanimous brief before him making this request and urging that chiropractic be placed on the same basis as medicine, the workmen to be given the privilege of choosing to whom they wished to go. Representations were made by labour and even industrialists and employers throughout the whole province testifying that labour hours would be saved by chiropractic inclusion due to decreased period of disability and lower cost of treatment and the vast logging, mining and agricultural industries of British Columbia would be thereby benefited.

Mr. Justice Sloan in his report stated that it had been substantially proven in evidence before him that some 1,300 injured workmen yearly under the Workmen's Compensation Act attended chiropractors and paid for their services out of their own pockets even though medical services were provided free. To remedy this, the British Columbia Act was then amended to provide for payment for chiropractic treatments.

During the past several months the dominion council has conducted a survey, and from the results obtained it was found that there are at least 13,000 treatments given daily by chiropractors in Canada. We have found that at least 200,000 persons, including many thousands in the armed services, took chiropractic treatments in the past year. In the last ten years, allowing for the number of patients repeating, etc., we believe that based on our surveys, we are absolutely accurate in saying that at least two million persons in Canada availed themselves of chiropractic treatments and of this number, a large percentage depend solely on chiropractic for their health needs.

In other words, it is proposed in this Health Insurance Act to force two million people in Canada to pay annual contributions to this medical fund a minimum of \$26 and a maximum of \$78 per year, be they of moderate means or great wealth, and at the same time deny them the right to go to a chiropractor unless they pay for this service out of their own pockets. Since it is proposed to cover the whole population, every citizen in Canada will be required to pay to this fund even though they may not wish to avail themselves of the medical and other services provided. The chiropractic profession is not selfish in asking that the contributors of health insurance be entitled to choose their services. We simply point out that we are guardians of the health of the people to the extent of some two million out of eleven million and that to this extent the democratic principle of the law of freedom of choice of health practitioner will be denied. If contributions were voluntary we could have nothing to say, but if the act is carried through as drafted, without a vote on the subject, without consent, and, we suggest, in the case of at least two million people, directly contrary to their wishes, they will be regimented into contributing to a fund under the national health scheme which recognizes only orthodox medical benefits (which they do not wish) and ignores all others.

May I pause here to say that one of the members of your committee, Dr. McCann, in connection with the brief presented by the Christian Science practitioners last Tuesday asked this question: What about Christian Science contributions to the essential health and preventive services already in existence such as street cleaning, water purification, removal of garbage? Well, in the first place, I cannot help but say that my understanding is that these are always civic obligations paid for by direct taxation on property owners and I fail to see anything either in this act or the proceedings that have taken place before this committee which would indicate that there is any likelihood of these services being extended; but if it were the case would you say that 2,000,000 people in Canada should have to pay to maintain services which they have had, and which have always been paid for by direct taxation, wholly without benefit simply for the purpose of giving some kind of service to the rest of the population? Dr. McCann then went on—

Mr. VENIOT: I would just like to correct a misapprehension which exists in the minds of a great many members of the committee. The speaker said that in the last year 200,000 persons, including many of those in the armed services took chiropractic treatment in the past year. Then he goes on to say, "in the past it has been 2,000,000 people"; then he says, a little later on, "2,000,000 people" and he implies that that refers to one-fifth of the population of Canada at the present time. He most likely means 2,000,000 people over a period of ten years, not one-fifth of the population. I would like to straighten this point out.

Dr. McCANN: Might I suggest that in this as in other presentations that the witness should be permitted to make his presentation and that we should not be permitted to ask questions until the brief has been completed.

The CHAIRMAN: That is fine. Dr. Veniot was merely asking a question to get a point straight.

Mr. VENIOT: I agree entirely with what the hon. member says; but this is such a contradiction, and such a glaring statement, that I thought it should be called to attention immediately. It really refers to 2,000,000 people over a period of ten years, and that is not the same as the implication intended now, that it applies to one-fifth of the population in one year, as this brief might lead one to conclude.

THE CHAIRMAN: May questions be deferred until the brief is completed?

The WITNESS: The people of Canada have availed themselves of chiropractic practice, and will again when the occasion arises—of course, that applies over a period of time.

Mr. CLEAVER: Surely we are not all going to doctors every day.

The WITNESS: Now, Dr. McCann, I want to be fair on this—

Mr. McCANN: If we are going to defer questioning until after the gentleman has presented his brief, then I submit that we defer the discussion of any statement which I made on a previous brief until such time. And, I doubt whether it is within the competence of the gentleman who is presenting this brief to make any submission with respect to what I might have said at another time concerning another brief.

The CHAIRMAN: That is his privilege. Will you proceed, please?

The WITNESS: Yes, thank you, Mr. Chairman; I just wanted to complete this because the presentation was not quite complete.

The question might be asked as to what kind of people entrust their health problems to the hands of chiropractors: John D. Rockefeller, Sr., the richest man in the world, patron saint of the medical profession, with every means at hand to secure unparalleled medical talent, had a chiropractor in regular attendance during the last 25 to 30 years of his life and he lived, as you will

remember, to almost 100; the present King George VI of England and his brother the Duke of Windsor, depend upon chiropractors for injuries received in golf and horseback accidents; the Yankee baseball team never won a world series until they took on chiropractic trainers in 1919.

Some Hon. MEMBERS: Hear, hear.

The WITNESS: In Canada, chiropractors have numbered among their patients members of the dominion cabinet, premiers and cabinet ministers from the provinces, chief justices and other distinguished jurists, university professors, bishops and other clergymen, generals and other high officers in the armed services and many others prominent in the political and commercial life of Canada; and I venture to suggest members of the House of Commons of Canada and perhaps even members of this committee, although perhaps not all.

A word might be said in regard to the armed services. The same proportion of chiropractic patients exists in the army, navy and air force as in civilian life. It has been the policy of chiropractors not to charge a fee to soldiers. Many soldiers do not receive as large an income as they did in civilian life and are now not only unable to receive chiropractic treatments since soldier chiropractors may not practise in the army, but they are unable financially to afford chiropractic services for their families. They themselves can receive free medical attention in the army, but instead they flock in large numbers to chiropractors.

It might also be noted that during the depression a large proportion of our citizens were on relief and while medical doctors received lower fees, they nevertheless were paid for services to these indigents. Chiropractors performed valiant services during those years administering to the indigent sick and received absolutely no recognition from the government and no relief contributions. While it is not our policy at this time to consider the act from standpoints other than our own position, nevertheless, we cannot refrain from commenting on the statement of the honourable Minister of Pensions and National Health in his presentation to the committee, March 16, 1943 (Proceedings, page 22), where he says, "The cost of illness in Canada is known. A special study was made by the Bureau of Statistics in 1935 and the figure was \$240,500,000." This was a depression year and chiropractors treated the indigent sick without remuneration and reduced their fees to others. Medical doctors received lower fees. Thousands of people in Canada who wished to pay their way and would not accept relief got along without medical care. How can we then say that this was the cost of sickness in 1935. This was only the cost of what people could afford to pay for sickness in 1935. Under health insurance where the bill is paid we venture to suggest that there will not be enough medical and other health personnel in Canada for many years to come to take care of the immediate need. There will not be one-half enough hospitals to provide for those who will request and be entitled to hospitalization. Therefore, the greater will be the need for chiropractors.

I wish to make a statement which was not possible when this brief was prepared and that is that I am instructed by the dominion council to say that we are submitting, and will submit here, a plan that hospitals be provided for chiropractors. At the present time, as you know, hospitals are overcrowded and it is not possible for chiropractic patients to receive these services in these hospitals. And now, chiropractic I say is here to stay and chiropractic must be recognized and reckoned with in future plans on health in Canada, and we suggest this: we propose that a hospital be built for drugless practitioners and we are quite content that they have medical men on the staff; and we are quite content to see how we can work with medical practitioners; and if at the end of some time it is found to be satisfactory then we think we will have proof that we are right, that we are not offering obstacles, and that can be done. Now, I am asking Dr. Sturdy a little later on, after I have finished, to amplify that and explain to you exactly our position.

4. *Public Demand for Chiropractic*

We are confident in our accuracy when we say that at least 40 per cent of the people of Canada are demanding the right to choose their own health practitioner. Much publicity was given to the statement that under this plan the citizens could choose their own doctor. A tremendous number of people believe this to mean that they may select a chiropractor. We have been daily flooded with inquiries in reference to this position and as yet we have to tell them that this is not the case. No such right is, up to the present, contemplated. In the short time that has elapsed since this committee commenced its deliberations, a petition has been allowed to circulate among the people of Canada. That petition, members of this committee, was not urged, it was left in offices and that sort of thing, but there was no active campaign. Here are the petitions. I have them right here and I will leave them right here. They are signed by 55,993 voters and tax payers of Canada with their addresses. Since this brief was signed on Monday another 578 names came in.

The petitions read as follows:—

To the Prime Minister, members of the government, and members of parliament for the Dominion of Canada:

We, the undersigned, citizens of the dominion of Canada, do hereby command of you by this petition:—

That, any health legislation being brought into effect in the dominion of Canada, or its provinces, shall give the citizens thereof the right to choose the practitioner of their choice regarding their health matters, and that no special group of practitioners, medical or otherwise, shall be given dictatorial rights regarding treatment or prevention of disease. The right of the citizen to the practitioner and method of treatment of his choice is irrevocably bound up with the duty of the state to see that such a choice is made possible.

We, therefore, demand the same freedom regarding our health needs as we do regarding our religious freedom.

To all of which we humbly pray—

Surely this is sufficient evidence to show the vast numbers of our citizens who will not be content with the denial of their freedom of choice of health practitioner.

In the province of British Columbia a short time ago, a card was distributed with these questions:

1. Have you received benefits from chiropractic?
2. Do you demand the right to choose a chiropractor under National Health Insurance?
3. Are you in favour of chiropractors practicing in the armed services?
4. Has any of your family been cured by chiropractic of a disease diagnosed as incurable by the medical profession?
5. Have you or anyone of your family avoided a surgical operation considered necessary by a surgeon?

In about two weeks, (counted to last Saturday morning, May 29th, 1943) we received in reply 2,904 cards. I have here a bundle of these cards.

I am informed that up to yesterday there were another 400 received. I could not bring them all but I will send the rest if you desire. By that time, there will be hundreds more.

Here are the answers:—

Question	Yes	No	Unanswered
1	2,747	104	53
2	2,879	11	14
3	2,857	4	43
4	991	1,180	733
5	947	1,201	757

In other words 97·61 per cent have received chiropractic benefits, 99·1 per cent demand the right to choose a chiropractor under the Act, 98·38 per cent want chiropractors to practise in the army and even as large a percentage as 34·1 per cent have gone on record as saying that they or members of their families have been cured of a disease diagnosed as incurable by medicine and 32·33 per cent have avoided surgical operations through chiropractic.

This was only one province where there are only 71 chiropractors or about 10 per cent of those in Canada. This is only a cross-section of opinion. Results across Canada would show no doubt ten times this amount and had time permitted many more thousands would undoubtedly have been received.

On May 14, 1943, Mr. H. H. Hannam, President of the Canadian Federation of Agriculture filed with you their booklet entitled "Health On The March". I would refer you to page 310 of the proceedings of your committee where this pamphlet says:—

There is no doubt that one of the questions in the minds of the public to-day is—What about other professionals in the health field, whom they have become accustomed to using and whose services have been of benefit? In other words, what about osteopaths, and chiropractors? To our mind, there are two procedures to be followed: either that these services should be recognized under a national plan; or that their work should be incorporated into the course of medical training. This is a situation the public expects to be clarified.

Here is an independent survey conducted by the Canadian Federation of Agriculture showing that the public of Canada expects the recognition of chiropractic services.

Mr. Percy R. Bengough, acting president of the Trades and Labour Congress of Canada, in presenting a brief to you on behalf of that body on May 18, 1943 (Proceedings, page 331), said that organized labour of Canada requested recognition of chiropractic treatment in the bill. He pointed out (page 333) that the measure should be framed "so that first consideration is given to protecting the interests of the great mass of those whose health it is designed to protect, and that the interests of others who are to be employed to render the necessary services under the Act must be of secondary importance". Now in making this presentation it must not for a moment be forgotten that Mr. Bengough in fact did speak for that great mass, that is, the working men and their dependents, the protection of whose health is the paramount and avowed purpose of all plans for social security.

According to his figures, Mr. Bengough speaks for 264,375 members of organized labour. These members are, of course, the ordinary citizens, married men, heads of families with perhaps several dependents. Therefore, Mr. Bengough plainly and simply told you that he was the spokesman for easily three-quarters of a million people whom this Act affects.

Members of this committee, I put it to you frankly and directly—can you ignore this evidence? Can you ignore the voice of this unsolicited request from the fountain head of three-quarters of a million souls, that the services of

chiropractors be included in this bill? Can you ignore the request, nay the demand, of the thousands who have signed these petitions and these cards to the same effect? To be true to your obligations as members of the House of Commons of Canada and representatives of the voters of your several constituencies, you cannot ignore it. The time has now come when you may not and cannot brush aside the wishes and rights of so many people to use the services of the practitioners whom we represent, and still say that orthodox medicine contains the alpha and omega, the beginning and the end, of all knowledge of the healing powers of the human body.

5. *Chiropractic Success in the Treatment of Diseases*

The most competent judges of the value of chiropractic are those who have received chiropractic services and regained health. The affidavits and statements of thousands of people who have recovered their health through chiropractic could be produced before this committee. Chiropractors have literally made the blind to see, the deaf to hear and the lame to walk. In a survey conducted by Burton Shields, publishers of Indianapolis, Indiana, it was revealed that of 93,039 cases handled and results obtained from the reports of 412 practitioners who had kept accurate records, 79,222 or 85.15 per cent recovered or were greatly improved solely through chiropractic services. Ninety-one of the commonest diseases of man were included in these cases. In some instances 100 per cent recovery was made and in considering this record it should also be borne in mind that not only do chiropractors treat acute cases but a great many cases are chronic and although they may have been accurately diagnosed by medical practitioners they have resisted the traditional forms of treatment of orthodox medicine previously applied to them. In other words, where the medical treatment has failed these are the results obtained by chiropractors. Figures taken from the same authorities based on the influenza epidemic in 1918-1919 showed that medical doctors had one death in every 16 they had treated while chiropractors lost only one case out of 886. Comparisons made in May, 1936, revealed that in 658 cases of pneumonia medical doctors had 200 deaths or 30.4 per cent while 364 chiropractic cases saved 332, a loss of only 8.8 per cent. In insanity cases, chiropractors have had wonderful success. Results obtained on the mentally deranged have been prepared by the Jamestown State Insane Asylum, North Dakota, which is under medical supervision and the Forest Park Chiropractic Sanitarium of Davenport, Iowa. The medical asylum had only 27.8 per cent cures or satisfactory discharges while the chiropractic sanitarium had 65 per cent and this 65 per cent was obtained in cases mostly classed as incurable in insane asylums under medical care and were turned over to chiropractic years after their constitution was run down by prolonged mental disability. Many more cases could be cited but let us consider for a moment just one more. Practically every year there is a poliomyelitis scare; that dreadful disease that strikes terror into the hearts of all mothers when they hear the name. Medical doctors have absolutely failed to effect a cure of this disease. The "Science Sidelights" edited by Julius Dintenfass, B.S.C., D.C., of Brooklyn, New York, conducted in January, 1938, a survey of some 1,511 cases which showed the results obtained under chiropractic in acute infantile paralysis cases showed 71.5 per cent recovery and 20.8 per cent marked improvement, and in chronic cases 28.9 per cent recovery and 51.1 per cent marked improvement. Our medical friends say nothing can be done for infantile paralysis; we say that if chiropractic had every case of this kind in its first year, we could show complete recovery or at least a tremendous improvement.

So successful has chiropractic been in the treatment of these types of cases, as well as all accident cases, that over 200 health and accident insurance companies in the United States and Canada recognize the value of chiropractic

and pay for services to their insured. Most fraternal organizations and many employees benefit associations, one of which is the British Columbia Electric Railway Office Employees' Association of Vancouver, B.C., pay for chiropractic services for their members.

6. *Chiropractic is the Best Preventative Medicine*

Dr. T. C. Routley, General Secretary of the Canadian Medical Association, in his presentation to this committee on April 6, 1943 (Proceedings page 137) stated that the present programme of preventative medicine in the country is far from adequate. It has been urged repeatedly by witnesses before you that great stress will be laid in health insurance on preventative medicine. We submit that there is no greater preventative of disease in the world than chiropractic.

What has been the experience in the past in regard to preventative medicine. Dr. Heagerty in his presentation to you on March 19, 1943 (Proceedings page 47) says:—

It has been demonstrated that there has been no improvement in the health of the British people through health insurance since it was introduced in England, put into effect in the year 1912.

In the first year 60 per cent of the insured people called for the doctor and 60 per cent of the people still call for the doctor.

Does not this mean that despite health insurance, preventative methods as used by orthodox medicine have not succeeded? We take strong objection to any form of compulsion in either preventative medicine or treatment of disease. We are not attacking vaccination or inoculation for those who wish to avail themselves of these services, but are only against compulsion of any sort and believe in the freedom of the individual to choose.

7. *Chiropractic Cannot Be An "Auxiliary Service"*

Dr. Heagerty in giving evidence before this committee on March 30, 1943, (Proceedings page 118) said that chiropractic would be an "auxiliary service" to the medical and that "the insured person may not go direct to a chiropractor or osteopath but will be obliged to go to a general practitioner". We cannot stress too strongly that we believe this sort of a position is not fair to the general public much less to the medical practitioner and the chiropractor for many reasons. How can you expect medical men in Canada to examine 13,000 chiropractic patients daily and give a certificate to the effect that chiropractic should be used as an auxiliary service? They would not and could not honestly do it. Would it be fair to the chiropractors that they must send 13,000 patients per day to medical doctors for the certificate required to give them chiropractic treatment? Would it be fair to the public, to 13,000 patients per day to ask them to go through this sort of a procedure? Consider also the unfair cost thrown on the public such examinations would entail.

Chiropractic stands as a recognized healing science. If health insurance is made compulsory to all citizens of Canada you cannot expect them to forsake the chiropractic practitioners who have made and kept them well, and if you do not ask them to do so they will be forced to contribute to a fund which they will not use and pay for their health services out of their own pocket. The plainest principles of democracy forbid such treatment. If the medical men had all the means to keep the people well, there would be some argument but this we have amply demonstrated is not the case. Even the Right Honourable R. B. Bennett, Prime Minister of Canada (as he then was) said in the House of Commons in rebuke to medical doctors when asking for special privileges, "You cannot cure even the common cold".

At this point, members of this committee, may I say this personally, although I do not want to inject myself into it particularly. I have been cured many times of a cold just as it started by chiropractic treatment. It will come on one day, and I will be all crouped up. The next morning, through chiropractic adjustment, I will be completely well. Dr. Sturdy has one case to cite. We said we had thousands. He has one, and I will ask him to cite it after I have finished.

The other night in the hotel here in Ottawa I met a stranger. Incidentally, in the course of our conversation, he said that his wife had eaten some ice cream one day and shortly afterwards suffered a terrific pain. She went to the medical doctor and he said, "We will have to rush you right to the hospital and take your appendix out." She said, "Too late; I got it out last year." Those are not isolated cases. I was talking to a lawyer in Ottawa not long ago, and he told me that his child, two years of age, had been diagnosed as having a tubercular bone and would not live six weeks. He took the boy to a chiropractor, and to-day this boy is the leading hockey scorer in this city. Continuing:

Conclusion

I must apologize for the time I have taken, but in conclusion, I very briefly urge your most serious consideration to the presentation we have made. Chiropractors are the crusaders protecting the people's interests whose health is in their hands. Chiropractic has made the tremendous advances I have outlined. Chiropractors have kept down disease, they have obeyed health laws and they have earned their place as an established factor in the life and health of the nation. The public will not be regimented over to the will of organized orthodox medicine. The Magna Carta was forced on an unwilling king in 1215. Its main feature was to protect the life, liberty and property of the citizen from arbitrary spoiliations. If this government hands over to the medical practitioners control over the life and health of individuals, such steps will react against the government itself. We believe it our sacred duty to urge with every ounce of strength we have to see that as there is freedom of religion, so should there be freedom of choice in health matters.

We believe, however, that no sick person should go without proper treatment and that national health insurance is a tremendous forward step in the march of progress but only if it embraces the freedom of the people to choose their own health practitioner. The sole aim of chiropractic is to relieve suffering humanity and enable it to enjoy health to the fullest extent.

The CHAIRMAN: Are there any questions?

Mr. FULFORD: Yes. I should like to ask a question or two. First I should like to preface my question by stating that, as you all know in this committee, I hold no particular brief for the medical profession; I have even spoken in this committee in favour of giving the chiropractors and osteopaths more say in relation to the administration of health insurance. But, on the other hand, there are certain statements in this brief which I do not think we can take without a considerable number of grains of salt.

First I shall ask three questions in one, which arise out of page 1 of the brief. There is a statement at the bottom of the page which says: "The education and training of chiropractors qualify them to treat the ailments, diseases, defects and disabilities of the people of Canada." Do chiropractors feel competent to treat such diseases as perforated stomach ulcers, gangrenous appendix, etc.; does a chiropractor feel competent at a time when a woman is in labour to determine whether the child should be born a natural birth or whether it should be born by Cæsarean section? I should like these questions answered, Mr. Chairman.—A. First I might say we pointed out very clearly in the brief that we refer cases of surgery to surgeons. We are not

allowed to practice midwifery and that sort of thing. I want one of the officers of this association to answer that which is peculiarly within his field.

Dr. CLUBINE: Mr. Chairman, in answer to that question may I say that the chiropractor takes the position very clearly that in specialized cases such as these three quoted we always refer them to someone for consultation; but that is good practice in every way. I understand the medical men are frequently doing the same thing, and we always do that—at least, that is my personal practice. To all these questions I can give the same answer—we always consider these cases should be referred to someone for consultation and then decide what should be done.

Q. Then the statement is quite erroneous that “the education and training of chiropractors qualify them to treat the ailments, diseases, defects and disabilities of the people of Canada.” You admit at the outset that you are not qualified to treat certain cases.—A. In their own field. That is all we say. We have our field, our medical man has his. This is not a controversy between the merits and demerits of the chiropractor as opposed to medicine. We say we want our place; we have a place.

Hon. Mr. MACKENZIE: I have two questions to ask. In the B.C. Act, which was passed in 1936 dealing with provincial health insurance which was never enforced, what was done with regard to chiropractic in the province?

The WITNESS: I may answer that in this way: as the health insurance Act in British Columbia was proposed the chiropractors opposed the bill as such and we were supported in that by the medical men who did not go for it and who deliberately said they would not have any part of it. It was opposed by the industrialists, by the Board of Trade, and although it is still in the statute book it was never operated and never will be operated.

By Hon. Mr. Mackenzie:

Q. I was asking you if there was any reference made to chiropractic in the bill.—A. We made a presentation before the committee in which we did not ask for any inclusion; we deliberately asked that the bill be shelved and there was no provision given in it and we did not ask for any. .

Hon. Mr. BRUCE: Mr. Chairman, the gentleman who has just spoken has referred to certain others who have given evidence, one of whom has just given evidence, as Dr. Clubine. I should like to ask if he is entitled to use the prefix “doctor” and if so in what province is he entitled to do so?

The WITNESS: Mr. Chairman, only in the province of Alberta; we have not asked for it anywhere else.

By Hon. Mr. Bruce:

Q. I should like to ask two or three questions with reference to pre-medical education. I think the speaker referred to the requirements before chiropractors enter the college. I should like to be quite clear as to what the requirements are.

The CHAIRMAN: Junior matriculation.

By Hon. Mr. Bruce:

Q. Do they have to pass in the subjects of chemistry, physics and biology, for instance, before they enter on the study of chiropractic?—A. Mr. Chairman, that is set out very clearly, Dr. Bruce, in the brief. Chemistry is required in some local acts and that sort of thing. Let me put it this way. I asked a chiropractor not long ago and he told me he went to college and the courses in medicine and chiropractic were identical up to one point, and then they branched off only for a few months or a year, whatever the case may be; he said they were

absolutely identical up to that point. We cover physiology, chemistry, pathology, psychology, medical jurisprudence, and so on. They are all set out on page 6 of the brief.

Q. I was asking you a question with regard to pre-medical education only.—

A. It is given in chiropractic colleges; then we have, of course, the technique and treatment in chiropractic, which is the last one enumerated.

Q. I should like an answer to the question.—A. All they have to have is junior matriculation.

Q. Do they pass any examination in these subjects to which I have referred, chemistry, physics or biology before they enter the school of chiropractic?—

A. Well of course, that is determined entirely by the provinces. To obtain a junior matriculation standing, as I understand it—it was necessary when I went to school to have one or two sciences, chemistry was certainly one. But the regulations and educational requirements of the high school courses change from time to time. They do not have to have a pre-med course before going to a chiropractic college, but they are taught the medical subjects in a chiropractic college. In order to enter a chiropractic college they have to have first junior matriculation, whatever that entails.

Q. Every medical student has one or two years in these scientific subjects before they are allowed to enter the study of medicine. You spoke of there being twelve schools of chiropractic in the United States; are there any colleges of chiropractic in Canada, and if so where?—A. There are twelve, a number of colleges in the United States, and there are none in Canada at the present time, there has been, but not at the present time.

Q. Because of what you stated as to the ability of chiropractors to cure disease, I should like to ask if you believe in the theory that micro-organisms are the cause of certain diseases. In other words, do you believe micro-organisms cause diseases?—A. I will have to ask Dr. Clubine to answer that.

Dr. CLUBINE: Yes and no. We believe the micro-organisms is the cause, the disease is secondary, that the predisposing factor lay there before the patient or person could be attacked by the micro-organism. We think it is secondary; that is, the patient would have a great deal of poison in the body before diphtheria or some other disease would attack it.

Hon. Mr. BRUCE: Do you believe, for instance, that a micro-organism does cause the disease which you spoke of, acute infantile paralysis or cerebral spinal meningitis?

Dr. CLUBINE: I am not sure that it has been definitely determined by anyone, but I believe that is generally conceded to be true.

Hon. Mr. BRUCE: In spite of that fact you believe you can cure this disease by chiropractic treatment, because your brief says so, and that in a very large percentage of cases you have succeeded in curing acute cerebral spinal meningitis cases by manipulation of the spine.

Dr. CLUBINE: Mr. Chairman, will you pardon a couple of personal references? Some years ago a mother brought a little boy about three or four years of age to my office with both legs just dangling, definitely pronounced as infantile paralysis. I have forgotten how many months elapsed, but the boy got completely well.

Hon. Mr. BRUCE: I am talking of acute, not chronic cases, but acute cases only.

Dr. CLUBINE: Dr. Bruce, I do not know, but my experience is we only get them like that for the simple reason the medical men take care of them. I believe there is a great field for us if the hospitals would let us come in earlier, but we get them only after they become chronic.

Hon. Mr. BRUCE: Then the statement on page 13 of this brief, where you say the results obtained by chiropractic in acute infantile paralysis cases show that 71·5 per cent recovered and 20·8 per cent a marked improvement, is not correct, I take it.

Dr. CLUBINE: On what grounds?

Hon. Mr. BRUCE: You say now that you do not get the acute cases.

Dr. CLUBINE: I said I did not; I have never had an acute case. I cannot cite these cases, because they came from the U.S.A. I do not know about the answer to that. They may have access to the hospitals; we have not.

Mr. JOHNSTON: Would Dr. Bruce say that the doctors can cure it?

The CHAIRMAN: We are not on that point just now.

Hon. Mr. BRUCE: I will answer that in a moment if I may.

By Hon. Mr. Bruce:

Q. I should like to have an answer from one of these gentlemen who is appearing; perhaps the president of the association. Would you attempt to treat the case of acute cerebral spinal meningitis, commonly known as infantile paralysis, by chiropractic treatment?

Dr. STURDY: Mr. Chairman, Dr. Bruce, I have had these cases and I have got good results in them.

Hon. Mr. BRUCE: You have cured them?

Dr. STURDY: Well, when you say "cure" that is quite a broad statement. I do not make that claim that we cure; we have given great benefit in those cases. The difficulty is as Dr. Clubine has just stated, we get the cases after our medical brothers have had them. I am talking about acute cases now. I will cite one case, that is all. A little boy about 2 o'clock in the morning shouted out and when his father went to his bedside he found he was limp on one side. A doctor was called and the child was sent to the hospital. The doctor injected twelve different kinds of serum into him. This little boy was six years old. His spine was tapped four different times during the week. Someone implored the father to come to see me. Well, the gentleman brought him in. They took him out of the hospital to get him to me; and there was a marked improvement right from the first adjustment of the first cervical vertebra.

Hon. Mr. BRUCE: How long after the beginning of the disease.

Dr. STURDY: One week. Does that answer at all your question?

Hon. Mr. BRUCE: Well, not entirely. I should like to ask you this: Are you aware of the fact that through a treatment developed over the last couple of years, one of the sulpha drugs will cure cerebral spinal meningitis in at least 90 per cent of the cases? Are you aware of that?

Dr. STURDY: I have heard that stated, but I would not accept that.

Hon. Mr. BRUCE: In the face of that would you still submit these cases to chiropractic treatment?

Dr. STURDY: Absolutely, yes.

Hon. Mr. BRUCE: You would?

Dr. STURDY: Yes.

Hon. Mr. BRUCE: I think your claim is extravagant and absurd.

Dr. STURDY: Dr. Bruce, may I say this, Mr. Chairman, that this is the third provincial legislative committee that I have appeared before and I have been before two royal commissions and I know this, that chiropractic and medical doctors can never get anywhere through argument, but the fact remains that we are getting the results, the fact remains that the people are flocking into our offices. They are not brought in through advertising. If you will allow me

to give a personal experience, last Friday, a week ago to-day, I checked up in my office on how many cases out of 31 had been to medical doctors before they came to me with their various troubles. All but two of them had been to a medical doctor. Two of them had never gone to a medical doctor, but the others all had, and with the exception of about five or six cases, which were fairly new, they were all showing marked improvement in their various complaints, which covered growth in the breast, paralysis in the arm, slight paralysis in the legs where they were able to walk with great difficulty, and so on and so forth.

Hon. Mr. BRUCE: I should like to pursue that.

The CHAIRMAN: I am afraid we will have to dispense with argument and keep to questions.

Hon. Mr. BRUCE: You were talking of chronic cases. I should like to ask if you are aware of the fact that in these severe acute cases of cerebral spinal meningitis the patient will live not more than four or five days or a week.

Dr. STURDY: Dr. Bruce, I have at least two of these cases that were diagnosed and had all the symptoms that you speak of and I was called in immediately and did get results immediately in these two cases.

Mr. MACINNIS: I should like to suggest to the witness that, as Dr. Sturdy said, we are not going to get anywhere by arguing. There is no necessity of getting hot and bothered over this sort of thing.

The CHAIRMAN: It is a hot day.

Mr. MACINNIS: The fact of the matter is, particularly as far as British Columbia is concerned, that a health insurance act which does not include chiropractors on a basis of equality with the medical profession will not be satisfactory. The medical profession has put up a strenuous case against the recognition of chiropractors in British Columbia, and despite that fact public demand has compelled the government, if I may use that word without any bad implications to it, to extend the facilities of the province to the chiropractors as has been indicated by the extension this last year under the Workmen's Compensation Act. I would like to refer to a question asked by Mr. Fulford in regard to caesarian operations and as to whether chiropractors were qualified to decide when one was necessary. I was reading an article a few days ago by a doctor which indicated that doctors were not qualified because he said that too many caesarian operations were being performed, performed where they were absolutely unnecessary; so a question of that kind does not enter into the matter at all. It is solely based on the service the chiropractors are able to give the people, and the people will demand that service.

Mr. McCANN: Mr. Chairman, I would like to ask a question or two. Is it not a fact that six out of twelve chiropractic colleges in the United States have been closed down? I think we are all very proud of our educational system both in Canada and the United States. It is broad and I think it includes every known science that is recognized throughout the world. I would like to ask the gentleman who presented the brief what is the significance of the fact that no recognized university in any country has, so far as we know, established a chair for the teaching of the system of chiropractic? No recognized university so far as I know in any country in the world has a chair within that university for the teaching of chiropractic. These schools which teach it have been established as separate entities. I do not want to comment at any length upon the brief. I am always glad to hear the briefs of any organizations which may wish to appear before this committee in order that we may receive enlightenment and give fair consideration to the case which has been presented. However, as I look over this brief and hear it, it contains so many inaccuracies and so many debatable statements that we have not time now to enter into any prolonged

discussion with reference to them, but I can say with reference to this brief, comparing it with briefs that have been submitted by other organizations, that this has got an awful lot of loopholes in it, an awful lot of inaccurate statements which I would be very glad at some time to have an opportunity to debate.

The WITNESS: I am going to ask Dr. Sturdy to answer the question. I might say first of all in reference to the colleges that I think we should bear in mind that chiropractors have been taken into the army and have volunteered. They are serving in all three services in tremendous numbers in the United States and Canada, and if there is a deficiency of students down there it is solely due, of course, to the war, but I think Dr. Sturdy can answer this question better than I can.

Dr. STURDY: It is true that six out of twelve approved colleges have been closed for lack of students. It is also true that the Palmer School, which was a very large one, has about twenty-five students there. When I was there in 1918 there were 1,300. First there were 650 and then the government of the United States gave an educational reestablishment grant to 500 chiropractic students. I believe that is the case in Canada.

We are facing almost complete annihilation of chiropractic if the war should last for ten or fifteen years. Most of us will have died or have become useless and we have not anyone to take our places. I am sure that will be remedied because this war is not going to last that long and we are going to get students. We are going to establish a college right here in Ontario, in Toronto, that will be controlled by the chiropractic council, by the chiropractors of Canada, where we will teach and turn out students of whom I do not think even our medical brothers would be too ashamed.

Mr. McCANN: In connection with the state university, the University of Toronto?

Dr. STURDY: Pardon?

Mr. McCANN: Would it likely be connected with the state university, the University of Toronto?

Dr. STURDY: I do not know. I know this, that unless we do the medical profession will be forced to instal a chair of chiropractic by public demand. If we build and equip a college and give proper standards of education then the medical profession will not be forced to instal chairs of chiropractic in the universities. It has got to come. We are here. We have proven ourselves. We do not have to go before anybody and prove ourselves, Dr. Bruce. We are here twenty-five years. At least, I am twenty-four years in Canada now. My friend, the Hon. Mr. Mackenzie knows me well. He will give me credit for being truthful. As a matter of fact he was my lawyer and saved me from going to jail for one to three months. I had my fingerprints taken and my picture taken and put in the rogues' gallery. I have that honour, gentlemen, of being in the rogues' gallery. I also have the honour of legally recovering those pictures and fingerprints and having them destroyed.

I say this, that I would be willing to come here before this committee whenever you wish and go right through that brief line by line, page by page. It is true there will be loopholes. We cannot be wholly accurate any more than our medical friends are accurate in a lot of their statements and statistics. You are accurate in statistics when it comes to costs of hospitals, and so on.

Mr. Chairman, would you allow me to say a word on the hospitals, and then I am through?

The CHAIRMAN: All right.

Dr. STURDY: I hope I am not called on any more. We have had the use of private hospitals back in Vancouver—at least, I have—for the last twenty years. We are barred from all public institutions. In these private hospitals I

have worked with medical doctors on cases, had them with me, good friends of mine to-day, always have been. We have had splendid results, and so on and so forth, but with the demand on the hospitals to-day these private hospitals are denied us. They are full. They cannot take chiropractic cases and, as a matter of fact, they have had to go back wholly to the medical profession. In my day the private hospitals had to get support where they could, either through medical or drugless practitioners. I claim in the future if this Act is implemented there is going to be a tremendous shortage of hospitals in the next five or ten years. It may cost this country anywhere from one-third of a billion to a billion dollars in the next five or ten years to establish hospital facilities that will be adequate to take care of the demand. Would it not be wise, and would it not be a good thing for the government to take two million dollars or three million dollars and choose twenty cities in Canada of 100,000 population and over and hand those hospitals over to the drugless practitioners to practice in working with our medical brothers? I would say there should be a house surgeon, there should be an obstetrician and there should be a general practitioner. We will work with them and it will be successful. Is that not a fair request to make, Mr. Chairman and gentlemen, that this be tried out? There is common ground on which we can meet and it is in the drugless hospital. I am sure of that. Then, in say five years we will have proven that it is common ground. Then open the doors of the hospitals all over the country and allow the sick to ask for their chiropractor or drugless practitioner to have admittance without having to sneak in the back door, or otherwise. Thank you.

Hon. Mr. MACKENZIE: There is just one question to which I would like to have a brief answer, if possible. Having regard to the considerable discretion the provinces will have in amending the model bill which has been drawn up and considering the fact that they have statutory rights in four of nine provinces what is your cardinal complaint in regard to these proposals?

The WITNESS: Mr. Chairman, I would say that this Act in itself is very specific in outlining the benefits and certainly no provision is made. In addition to that, as I understand it, there is no statistical basis made, or anything of that kind. This has all been gone over by the advisory committee without extending this service in anything but an auxiliary way which would be, of course, X-ray and physiotherapy in hospitals, and that sort of thing.

Hon. Mr. MACKENZIE: Your complaint is that the patient is compelled to go to a doctor first before he goes to a chiropractor?

The WITNESS: That is right, quite true. Before I sit down—because I probably will not be up again—just for the sake of the record I would like to make a statement. I think I said in answer to a question of Dr. Bruce that only in the province of Alberta are we entitled to use the title “doctor”, and I said we had not applied in any other province. I cannot say that is correct. We have not applied in British Columbia. Whether we have applied in other provinces I do not know. Perhaps I should point out when Dr. Sturdy mentioned about going to gaol it was for practising chiropractic, of course, in violation of the Medical Act.

Mr. GERSHAW: At the bottom of page 14 it is stated that the Right Hon. R. B. Bennett, Prime Minister of Canada, said in the House of Commons in rebuke to medical doctors when asking for special privileges, “You cannot cure even a common cold”. I well remember that time and I really feel that this does not express Mr. Bennett’s attitude to the medical profession. He did state that the germ causing the common cold may not have been isolated, but I think if the reference in *Hansard* is reviewed it will be found that this brief reference gives a wrong impression as to his attitude.

Mr. CLEAVER: Mr. Chairman, I simply rise to ask if you would be good enough to indicate what your plan is in pursuing this inquiry with respect to the chiropractors? After what I have heard to-day I am convinced that apparently a large section of our population have had highly beneficial results from such treatments, and in view of that I do think the present hearing should not be rushed, that great care should be taken and the fullest possible opportunity given for representatives of the chiropractors' association to fully present their case to the committee. I well remember that we took many days with the recognized medical men in hearing their presentation.

The CHAIRMAN: Various phases of their work.

Mr. CLEAVER: I think various phases of the work of the chiropractors should also be heard. That is only my personal opinion but I am rising to express it. The Minister just before leaving asked the witness what his cardinal complaint was with respect to the present Act. I wish to at once go on record as to what my cardinal complaint is with respect to the present Act. After hearing the medical members of this committee express themselves—

The CHAIRMAN: Would you defer your personal opinion until we discuss the bill?

Mr. CLEAVER: I think perhaps I could but I will be short.

The CHAIRMAN: We have a number of witnesses here still who have come a long distance.

Mr. CLEAVER: I bow to your decision, but my complaint is that I do not think any doctor, certainly those who have spoken to-day, will send a man to a chiropractor.

The CHAIRMAN: May I point out, Mr. Cleaver, that Dr. Sturdy will be available for consultation by the committee at any time, I understand.

Dr. STURDY: Yes.

Mr. MCGARRY: As one of the medical men who think the chiropractor has his place in the community may I have the privilege of asking a question of Dr. Sturdy with a view to getting an expression of opinion from him as to what I consider an important point? I find that the main protest against the widespread practices of the chiropractic arises from a situation which I have witnessed right at home in my own province of Nova Scotia. For instance, you take a case of incipient tuberculosis which has been diagnosed definitely as a case of tuberculosis and the patient is advised to go to a sanitarium for treatment, and a chiropractor who is carrying on his practice in the town suggested to these people that if this case were submitted to his care he would see that the patient would be taken from the pathological doldrums. Now, I believe that this man while he was practising in that town had done some very good work so far as he applied himself to the qualifications and the privileges of his practice. That is one thing that we medical men in my province are protesting against; that the chiropractor is exceeding his field of practice; just the same as a medical man who knows only the medical treatment side of medical practice would be exceeding his field of operation if he were to go into a hospital and practise surgery. That is one of the things that we have to complain about with respect to chiropractors practising in our province, that they are exceeding the bounds of their qualifications.

The CHAIRMAN: Dr. McGarry, do not the provincial legal authorities take care of that?

Mr. MCGARRY: Yes they could deal with it. We find it is one of the principle causes of complaint we have there.

The CHAIRMAN: I do not think this committee can deal with that.

Dr. STURDY: Could I just answer that?

The CHAIRMAN: If you make it very brief, please.

Dr. STURDY: Yes. I will. We are heartily in accord with your criticism. We do not agree with any chiropractor who interferes with tuberculosis institutions, and procedures of patients who are under doctors of that type; and when they come to us, and we believe that they are of that type—I would say that it is our object to try to uplift the chiropractor to the standing where we all want to see him.

Mr. McGARRY: What do you do in a case such as the one in my province to which I called attention?

Dr. STURDY: In our province we take him before our board and give him a talking to, and I believe it does him a lot of good. But, as I said earlier, there is a field for us; you have yours, and we have ours; we are not quarrelling with yours and we hope that you will give us the right to look after ours and build it up. There is a place where we will live together. In another ten years it will be a different story. Back in the province of British Columbia where I come from doctors are quite satisfied with our Act and with the way in which we are administering it, and with the way in which we have administered it since the year 1934.

The CHAIRMAN: We have also with us representatives of the Board of Regents, Toronto. Dr. Macfie, will you please present your brief?

Mr. BRUCE: Mr. Chairman, just to get the records straight may I ask the secretary who just read the statement (Mr. Burton) and who has placed a number of petitions before us whether this document which has been sent to a number of members of the house and the senate—I may say that I got this copy to-day from a senator; it is not signed by anybody—emanated from the chiropractic association? It is entitled, "The National Health Insurance Act—A Message of Vital Importance". The pamphlet which I have in my hand was addressed to Senator Ballantyne and it is stamped, Hamilton, May 20th.

Mr. BURTON: In answer to that, may I say, Mr. Chairman, that we have absolutely no affiliation with those people at all; I have never seen that document and we certainly accept no responsibility for it at all.

Mr. BRUCE: It makes some very damaging statements.

The CHAIRMAN: Thank you, Mr. Burton.

Dr. A. W. MACFIE, called.

The WITNESS: Mr. Chairman, Mrs. Casselman and members of the Social Security Committee; I am the secretary-treasurer of the Board of Regents administering the Drugless Practitioners Act for the province of Ontario. Our chairman, Dr. Detwiler, of London, will present the brief.

Dr. DETWILER, called.

The WITNESS: Mr. Chairman, I will assure you this is not a long brief. Our mission here is somewhat different from that of the other professions involved. We come representing the Board of Regents of Ontario who administer the Drugless Practitioners Act, and our submission will show you exactly where we stand. There is no question of organic therapy or anything like that; it is really a question of establishing educational, professional equipment to registrants under our act.

Mr. Chairman and Members of the Special Committee on Social Security of the House of Commons, Ottawa, Canada:

BRIEF OF THE BOARD OF REGENTS APPOINTED UNDER THE DRUGLESS PRACTITIONERS ACT FOR THE PROVINCE OF ONTARIO, BEING R.S.O. 1937, CHAPTER 229

The Board of Regents appointed under the provisions of the Drugless Practitioners Act of the province of Ontario, being revised statutes of Ontario, 1937, Chapter 229, is the official body appointed by the government of Ontario through the Lieutenant-Governor-in-Council to administer the Ontario Drugless Practitioners Act. Under the Ontario Drugless Practitioners Act the Board of Regents has vested in it, the general administration of the Ontario Drugless Practitioners Act and the regulations thereunder, a copy of which act is hereunto annexed to this brief. Under the Ontario act "Drugless Practitioner" includes every person who practises or advertises or hold himself out in any way as practising the treatment of any ailment, disease, defect or disability of the human body by manipulation, adjustment, manual or electro-therapy, or by any similar methods.

By regulations made pursuant to the act by the board and approved of by the Lieutenant-Governor-in-Council, the drugless practitioners registered with the board and entitled to practise as drugless practitioners within the province are divided into major and minor classifications. The major classification consists of osteopaths, chiropractors and drugless therapists. Under the regulations, osteopaths, chiropractors and drugless therapists, falling within the major classification as aforesaid, have the right to diagnose and treat any ailment, disease, defect or disability of the human body by drugless methods. They are prohibited by the act from practising medicine in that they are prohibited from prescribing or administering drugs for use internally or externally or to use or direct or prescribe the use of anesthetics, for any purpose whatsoever or to practice surgery or midwifery. With these exceptions, however, they are entitled to treat any member of the public for any ailment, disease, defect or disability he may be found to be suffering from, and to diagnose his ailment and prescribe drugless treatment therefor.

Before any student is allowed to enter a college teaching osteopathy, chiropractic or drugless therapy, he shall present evidence of having passed the matriculation examinations in Ontario or equivalent, this being the minimum requirements (osteopathic colleges require that all students entering their institutions shall have had at least two years college education in addition to high school graduation).

No school teaching osteopathy, chiropractic or drugless therapy is approved by the Board of Regents in the province of Ontario unless they give a course of at least four years of nine months in each year with a minimum required number of teaching hours being set at 4,200 hours. Every school or college approved by the Board of Regents of the province of Ontario, however, has a minimum course of at least 4,800 hours and some well over the 5,000 hours mark. Students must be instructed in at least the following subjects:—

Anatomy (including all branches, gross Anatomy, Dissection, etc.

Physiology
Chemistry
Medical Jurisprudence
Pathology
Psychology
Eye, Ear, Nose and Throat
Histology
Dietetics
Diagnosis

First Aid and Minor Surgery
Psychiatry
Gynecology
Bacteriology
Hygiene and Sanitation
Symptomatology
Obstetrics
Principles of Practice,
Technique and Treatment

These are the minimum number of subjects taught in approved colleges. Following graduation from an approved school, the candidate for registration and licence in the province of Ontario must then pass examinations, both written and oral, in the following subjects:—

Anatomy	Hygiene and Sanitation
Histology	Diagnosis
Physiology	Symptomatology
Bacteriology	Pathology
Chemistry	Gynecology
Dietetics	First Aid and Minor Surgery
Principles of Practice, Technique and Treatment.	

That gives you the educational standard of registrants under the act.

There are registered under the act at the present time 115 osteopaths and 417 chiropractors and drugless therapists, a total of 532 drugless practitioners, registered with the Board of Regents in the major classifications.

From a provincial-wide survey made by the board as of a recent date, it was found that there are approximately 8,000 treatments given daily by these practitioners and that during the year 1942 some 125,000 different persons in the province of Ontario were treated by osteopaths, chiropractors and drugless therapists. In other words, during the year 1942 there were approximately 125,000 persons living in the province of Ontario alone who looked to or were dependent upon the chiropractors, osteopaths and drugless therapists for their health needs.

Over a period of ten years a survey shows that there were in the neighbourhood of 800,000 persons in the province of Ontario who availed themselves of these forms of treatment. This refers to only one province. Figures for all Canada would, no doubt, run into millions.

According to the minutes of the proceedings before the committee on Tuesday, March 30, 1943, page 118, Mr. George Fulford, a member of the committee asked the following questions:—

MR. FULFORD: Mr. Chairman, I should like to ask a general question somewhat along the lines of Mr. MacInnis' question and on the closed shop. There is no provision to be made to include on these health committees or commissions, osteopaths, chiropractors and masseurs. After all, in a modern community, they do form, in so far as the layman is concerned, an important group and perform a useful service. Speaking as a layman myself, I cannot help but feel they perform a useful function.

The Chairman then asked Dr. Heagerty if he could answer the question and his reply was:—

DR. HEAGERTY: Well, the Greeks have a word for it, we have two. We call it "ancillary services". The doctor has the privilege of utilizing the services of the masseur, the osteopath and the chiropractor and any other service that he thinks his patient needs. That, I think, covers all these other questions.

DR. HEAGERTY: That word "auxiliary" in the second line there, should be "ancillary". Wherever that word "auxiliary" appears throughout that quotation, in fact throughout the brief, it should read "ancillary".

THE WITNESS:

MR. FULFORD: I rose to my feet on this point. I hoped that if the medical profession became all-powerful they would not outlaw the so-called drugless practitioner.

HON. MR. MACKENZIE: Would that not be a matter for the various provinces to decide, according to their own laws?

And I would like to stress that quotation.

Dr. HEAGERTY: It depends upon the definition of general practitioner. We have used, I think, Mr. Watson, the name "general practitioner". I believe in one province, and that is in British Columbia, the chiropractor—and I hope I am right in this; perhaps Dr. Amyot will correct me if I am not—is a general practitioner or general medical practitioner. There is some misunderstanding in connection with that, because at the meeting of the General Medical Council of Canada it was stated by representative of British Columbia that the osteopath, the chiropractor or naturopath, one, either, or all, were entitled to the term "general practitioner" in British Columbia. If that is the case, then the insured person may not go direct to a chiropractor or osteopath, but will be obliged to go to a general practitioner.

Mr. CLEAVER: Do I take it from that answer, Dr. Heagerty, that a person who is ill will not be able to have the services of a chiropractor under this Act, until the general practitioner recommends that he requires those services?

Dr. HEAGERTY: That is what they will have in mind.

Mr. CLEAVER: That would appear to be highly dangerous.

It would, therefore, appear from Dr. Heagerty's answers to these questions and from a reading of the draft Bill that there is to be no provision in the Bill for the including of the services of osteopaths, chiropractors and drugless therapists. If this is so, then a large proportion of the population will be forced to give up the form of successful health treatment which they are dependent upon, have confidence and reliance in, and substitute therefor a system they may have previously tried and found wanting.

Dr. Heagerty speaks about "ancillary services". There is no doubt that Dr. Heagerty has in mind the use of masseurs and physio-therapists and if reference is made to page 3, section 3, paragraphs 2, 3, 4, 5, 6, 7 and 8 of the Regulations made pursuant to the Drugless Practitioners Act, and a copy of which is attached hereto, it will be observed that the ancillary services referred to are taken care of in the Regulations.

Mr. CLEAVER: Mr. Chairman, may I call attention to the fact that the witness is quoting correctly from our records. Since Dr. Heagerty has said that he said "ancillary" service, I believe that correction should be made in our permanent records.

The CHAIRMAN: Yes, Mr. Cleaver. Thank you.

Mr. CLEAVER: It is "auxiliary" in the minutes. I checked them.

Mr. McCANN: The word in the Act is "ancillary".

Mr. CLEAVER: Yes. But Dr. Heagerty is reported as using the word "auxiliary".

Dr. HEAGERTY: I used the word "ancillary". I was quoting the Act at the time.

Mr. CLEAVER: It is a stenographic error.

The CHAIRMAN: The correction will be made. Will you proceed, Dr. Detwiler.

The WITNESS: (Continuing)

The regulations provide that no physio-therapist or masseur shall undertake the treatment of any ailment, disease, defect or disability of the human body except upon prescription of a legally qualified medical practitioner, chiropractor, drugless therapist or osteopath.

In other words, it is only the major classification, namely, the osteopath, chiropractor and drugless therapist who may diagnose and treat members of the public for their ailments or disabilities. The minor classifications consist-

ing of the masseurs and physio-therapists may not diagnose at all and may only treat members of the public for ailment, disease or disability on the prescription of a duly qualified medical practitioner or of a duly registered chiropractor, osteopath or drugless therapist.

In the brief presented by Dr. Routley on behalf of the Canadian Medical Association to the committee on Tuesday, April 6, 1943 (see page 145 of Report of Proceedings):—

There are within Canada, also, certain groups who do not accept medical services—at least at times. They all, however, have been the beneficiaries of preventive and public health services and most of them, sooner or later, of diagnostic and treatment procedures as well. Apart from this, however, all our citizens have a common community obligation. There is probably no argument which can be advanced in support of the exclusion of certain groups from participation in any plan which was not advanced two or three generations ago in opposition to the inclusion of the general population in a scheme under which all were taxed to support our great public school system, even though all do not avail themselves equally of its privileges. It should be quite proper, of course, for certain individuals, if they so desire, to obtain their health care outside of the provisions of any insurance scheme, even as individuals now use schools which are apart from those provided under the authority of our Public or Separate School Acts.

The obvious inference to be drawn from this statement is that each member of the public will be required to make his annual contribution to the fund but will be required to receive medical treatment from a duly qualified medical practitioner only, and if he wishes to avail himself of drugless treatment supplied by osteopaths, chiropractors and drugless therapists, will have to do so at his own expense and without any help from the fund which his payments helped to create. It is submitted that any health legislation to be enacted by the dominion government should provide that a person entitled to benefit under the Act should be entitled to choose his own form of health treatment and should not be limited to treatment from a single profession.

I should like to interject just one remark here. It is quite true that all of us do benefit by medical services, preventive medicine, public health and all that sort of thing. There is no question about that. Whether we take osteopathic, chiropractic or other treatment, we are, first of all, citizens of Canada. As such we are proud of the advance that has been made in public health, and we do receive benefits there. But osteopaths, chiropractors and drugless therapists do treat a lot of people in the lower-wage brackets who would find it a very great hardship, if not impossible, to pay the full contribution for medical service and then go outside and pay in addition for their chiropractic or osteopathic care. I want to bring that out. Continuing:—

If, as has been suggested, dominion legislation takes the form of supervisory and enabling Acts, with the administrative and executive legislation being left to the individual provinces, we submit that in the dominion Act the wording should be such as to place no handicap on the provinces to include the services of osteopaths, chiropractors and drugless therapists among those on whom the public, entitled to receive medical and other available health services, may call. As each province will, as heretofore, administer its own medical and other health Acts, any dominion legislation should not make it impossible or difficult for the provincial legislation to cover such services for the public as its previous legislation provided.

With the way the Act is at present worded, we feel that it would be impossible for any one province—Ontario, for example, the one we are concerned about

—to make any provision for these in the Act. We should like to see the wording changed just to that point, that Ontario, if she so decided, could include them. We feel the wording of the Act needs a little change there. Continuing:

The drugless practitioner being recognized by law as having the right to diagnose and treat any ailment, disease, defect or disability of the human body by drugless methods and a large proportion of the population being dependent upon them for their health needs, that it would accordingly be unjust and inequitable for legislation to be passed which is not all inclusive and which prefers one class or profession to another while requiring compulsory contributions from the population as a whole.

As the governing body of the Drugless Practitioners Act in the Province of Ontario, we wish to be on record, and to impress upon the committee, the necessity of the inclusion in any health Bill to be enacted, the chiropractic and osteopathic professions as well as the medical and other professions.

The CHAIRMAN: Thank you, Dr. Detwiler.

By Mr. Veniot:

Q. May I just ask one particular question. Will the speaker be good enough to tell us how many drugless healers or drugless practitioners were permitted to practice by the Act when it was passed, and how many have undergone examination subsequently in order to register?—A. May I ask our secretary to answer that, if he can. It is quite a question.

Dr. MACFIE: I did not just catch what you said there.

Mr. VENIOT: I want to know how many drugless practitioners were permitted to practice by the Act itself when it came into force, those who had been practicing previously to the passing of the Act, and how many have been registered since by examination.

Dr. MACFIE: That would include from 1926 to the present time. I cannot give you accurate figures from memory. If you will give me your name and address, I will be glad to send that information to you. Would you give me your name?

Mr. VENIOT: My name is Veniot.

Dr. MACFIE: If you will give me your address, I will be glad to send that to you directly, or to the committee. Do you want that in the major classifications alone or the major and minor classifications? In Ontario we have, as you know, the Drugless Practitioners Act which covers everything excluded from the Medical Act; in other words, osteopaths, chiropractors, drugless therapists, physio-therapists, masseurs, and chiropodists. Do you want the number of each of those registered in 1926 and the number of each of the classifications that have come in since that date, and the number that have died? Or do you want the first registration or how many have come in since then and in each classification?

Mr. VENIOT: Just the chiropractors and the osteopaths.

Dr. MACFIE: That have come in since 1926.

Mr. VENIOT: Yes.

Dr. MACFIE: You want to know how many have passed examinations since that date?

Mr. VENIOT: Yes.

Mr. CLEAVER: I suggest that information should come to the chairman of the committee and be put on the record.

Mr. VENIOT: We want to know how many were permitted to practice by the Act itself when passed. Before the Act was passed let us say there were 400 or 500 drugless practitioners, or drugless healers in Ontario, who were not registered. How many of these did the Act qualify to practice?

Dr. MACFIE: In 1926?

Mr. VENIOT: Yes; when the Act was passed.

Dr. MACFIE: And how many have passed examinations since?

Mr. VENIOT: Yes.

Dr. MACFIE: I shall be very glad to send that information to the chairman of the committee.

The CHAIRMAN: Thank you. Are there any other questions? If not, on your behalf, gentlemen, I should like to express our thanks to the chiropractors and to the members of the Board of Regents for their presence here to-day. I understand that a member of each group will be available for consultation with the committee, if required.

We will adjourn until Tuesday next.

The committee adjourned at 1.00 o'clock p.m. to meet again on Tuesday, June 8, at 11.00 o'clock a.m.

APPENDIX "A"

SOME ADDITIONAL INFORMATION CONCERNING THE VENEREAL DISEASES IN AN EDUCATIONAL PROGRAMME

The Gallup Poll in April, 1943, at the suggestion of the Health League of Canada conducted an inquiry as to whether an educational programme concerning venereal disease was desirable. The following were the results, published on May 15:—

	Per cent
Would be a good idea.....	90
Would not be a good idea.....	2
Undecided	8

The percentage of replies approving of an educational programme is said to be the highest percentage ever reported by the Gallup Poll in favour of any project.

Report on routine blood tests (Wassermanns) on hospital patients admitted to Toronto General Hospital (with the exception of private cases) over a period of years. This test is one on patients admitted irrespective of the condition for which they are admitted. The figures are a percentage of the total admissions to the hospital per year:—

	Per cent		Per cent
1916.....	10.4	1930.....	3.4
1917.....	9.95	1931.....	2.7
1918.....	5.9	1932.....	2.5
1919.....	8.8	1933.....	2.5
1920.....	9.0	1934.....	1.7
1921.....	6.3	1935.....	1.5
1922.....	6.0	1936.....	1.7
1923.....	6.2	1937.....	1.5
1924.....	5.6	1938.....	1.5
1925.....	5.8	1939.....	1.4
1926.....	4.5	1940.....	2.0
1927.....	3.8	1941.....	2.5
1928.....	3.5	1942.....	3.4
1929.....	3.2		

Report on Cases of Early Syphilis in Toronto General Hospital over a period of years:—

1921.....	29	1932.....	80
1922.....	43	1933.....	73
1923.....	43	1934.....	76
1924.....	42	1935.....	54
1925.....	41	1936.....	41
1926.....	42	1937.....	41
1927.....	40	1938.....	68
1928.....	74	1939.....	103
1929.....	86	1940.....	109
1930.....	95	1941.....	131
1931.....	79	1942.....	145

Preliminary report on a survey done in the city of Toronto in the month of April, 1943. This survey carried on under the joint auspices of the Academy of Medicine and the Health League of Canada consisted of forwarding a questionnaire to all physicians and institutions inquiring as to the number of cases actually under treatment at a given time.

To date 913 physicians have replied to the questionnaire, 42 have not replied. Most institutions have replied.

The figures given refer only to early syphilis (new cases) and a comparison is included of figures as to a similar survey conducted in 1937:—

	<i>Clinics</i>		<i>Physicians</i>	
	Male	Female	Male	Female
1937.....	71	84	149	89
1943.....	246	235	281	173

Totals

1937—Male..... (new cases)	220
1937—Female..... (new cases)	173
(1937) Total.....	393
1943—Male..... (new cases)	526
1943—Female..... (new cases)	408
	934

A statement as to occupation of women attending one clinic on May 26, 1943.

Boxmaker.
Housewife.
Housewife.
Postal clerk.
Charwoman.
Housewife.
Living at home.
Inspector.
Charwoman.
Housewife.
Housekeeper (hotel).
Private nurse.
Cleaning—departmental store.
Waitress—cafe.
Housewife.
Waitress—milk bar.
Laundry sorter.
Photo-finisher.
Housewife.
Marker.
Munitions worker.
Hostess—optometrist office.
Trimmer—belts.
Clerical worker—industrial plant.
Salesgirl—dresses—departmental store.
Bank-clerk.

Operator—not war work.
 Machine operator—war work.
 Clothes sorter—not war work.
 Assembler—not war work.
 Selling cigars.
 Housewife.
 Sorting—bottle company.
 Housewife.
 Machine binder—industrial corporation.
 Operator—munitions plant.

Marital Status of above

Single	12
Married	15
Separated	6
Widow	3

A STATEMENT AS TO INFORMATION GATHERED FROM AN INSPECTION OF A
 FEW SOCIAL CASE SHEETS

A social history is taken in connection with each venereal case with a view to ascertaining the name and address of the source of infection as well as an understanding of the conditions under which infection takes place. A large proportion of these sources of infection were not paid.

- Case 1.—Met source in Lunch, Queen St. Went to room in Hotel.
- Case 2.—Picked up girl at Hotel. Went to rooming house on Dundas street.
- Case 3.—Met girl at dance at Hotel. Went to rooming house.
- Case 4.—Met girl in beverage room. Rented room in hotel for time being.
- Case 5.—Met girl in beverage room. Went to Hotel, Jarvis street. Thinks girl came from the country.
- Case 6.—Met girl on party. Took her to house on Elm street.
- Case 7.—Picked up girl in car. Took her to his own house.
- Case 8.—Picked up girl in show. Went to a room on Richmond street. Paid 50 cents.
- Case 9.—Picked up girl in hotel. Went to rooming house on George street. Says there are lots of rooming houses to which one can go.
- Case 10.—Picked up girl on Jarvis street. Took her to Hotel.
- Case 11.—Picked up girl on Queen street and went to his own room.
- Case 12.—Met source at a dance at the Hotel
- Case 13.—Infected at Pembroke street.
- Case 14.—Met girl at Hotel.
- Case 15.—Picked up girl on Church street but too drunk to know where he went.
- Case 16.—Met girl in hotel room, Brockville.
- Case 17.—Girl—Goes to wherever she is taken for the night,,,, etc., or rooming house.
- Case 18.—Met girl at Hotel. Went to house on Sherbourne street.
- Case 19.—Picked up girl at Hotel and got room there.

Out of 60 cases in only 10 was there direct evidence of money being paid. In 42 no money was paid. In 8 cases there was no information on this matter.

APPENDIX "B"

BRIEF TO THE SPECIAL COMMITTEE ON SOCIAL SECURITY OF THE HOUSE
OF COMMONS SUBMITTED BY THE HUMAN ADJUSTMENT INSTITUTE,
VANCOUVER, B.C.

Your committee are asked to carefully consider in its survey on the question of National Health, the rapidly growing practice on the part of a large number of people, of relying for the maintenance of their health entirely upon an organized and scientifically planned system of nutrition under the supervision of persons especially trained in this branch of science.

The consumption of food by the average individual may either be the *cause* or the *correction* of many types of ill-health. This recognition has been acceded by a large group of scientific research bodies and by a branch of the Dominion Government, until to-day a special branch of science deals exclusively with the question of the nutrition of the human body.

The Dominion Government, by establishing a nutrition branch in the Department of Pensions and National Health under the directorship of Dr. L. B. Pett, has specifically recognized this fact. This branch has recently carried out one of the most comprehensive programs of mass education that has ever been presented to the Canadian people. Its purpose was to encourage the public to eat wisely for the purpose of maintaining health in war time when the services of the physicians were needed to aid the war effort; and it may be suggested that this is a good policy both in times of war and in times of peace.

For the past 20 years a number of outstanding institutions have been created for the purpose of educating men and women to aid in the correction of disease through the processes of nutrition. Briefly we may say that the work of the institutions has established in a vast section of the public mind, the desirability of correcting ill-health through food rather than through medicines of one kind or another. These institutions, such as the Battle Creek Institute, the Department of Nutritional Research at John Hopkins University, the Lee Foundation of Wisconsin, the Lindlahr School, Chicago, Illinois, the Hauser Institute at Los Angeles, the British Institute of Nutritional Research of London, England, as well as many other institutions which were flourishing upon the continent of Europe prior to 1939, have made such advances that treatment by diet has become a recognized therapy. Upwards of 5,000 research workers have been engaged for years in the intricate work of nutrition, and to-day the results of their findings are to be found in our knowledge of. . .

1. Vitamins—and the important place that they play not only in the correction but in the prevention of diseases.

2. Minerals—the proper use of minerals; the deficiencies in the bodily structure which are occasioned through the lack of mineral-bearing foods and the correction of bodily deficiencies that can be obtained through inclusion in the diet of foods containing proper mineral substances. In this field lies one of the greatest hopes for the prevention of the deficiency diseases.

3. Hormones—and the important value of hormone foods in remedying deficiencies in the endocrine system.

4. Caloric values—the importance of the quantity of food consumption being now considered vital to the maintenance of health.

These and many other phases of nutritional research have been made available; but it would be foolish to suggest that they could be put into practice by the average person without technical advice and supervision.

This department of science, relating to the maintenance of public health, is a department which does not necessarily fall within the purview of the medical practitioner. Unfortunately a vast number of medical practitioners are violently opposed to the practices of nutrition; yet science has proven beyond any measure of doubt that nutrition does accomplish the desired end. Yet the majority of the specialists in the field of nutrition are not medical practitioners but scientists who have specialized in the chemistry of food and its effects upon the human body.

It is now being clearly established that nutritional programmes *alone* may correct such conditions as the common cold, constipation, arthritis, rheumatism, uremia, auto-intoxication, super-acidity, sub-acidity, deramititis, anæmia, as well as a host of allied conditions. It has proven that these conditions may be corrected *permanently*; that once a person has been properly instructed in the food they may eat, not only is the condition eventually corrected, but a person may be given further instruction that will prevent a recurrence of the condition.

The vast number of people who have become interested—partly through the government's educational programme and partly through other educational programmes—in this type of treatment, are now faced with the possibility that if this treatment is not included as a *separate department* in the National Health Insurance Act, that they will be unable to secure it excepting at their own cost despite the fact that they may be contributors to the national health plan. It is not to be expected that this vast number of people will be able to secure this type of treatment from the medical practitioner due to the fact, before stated, that many medical practitioners do not approve or are not qualified to give nutritional instruction that accords with the latest scientific findings. This statement is made with every respect for the medical profession which is a vital necessity to the health and well-being of the public, but a large number of the members of that profession quite openly state that they know nothing of nutrition and do not have the time to return to school and study it in the way that it would have to be studied if one is to use it exclusively for the purposes above noted.

Accordingly this institute recommends to your committee that some provision be made in the act that will permit the provincial governments—who presumably will be responsible for the administration of the act—to provide for payment to registered or recognized nutritionists of the proper fees for the care and instruction of people who prefer to submit themselves to this type of treatment rather than to the treatment of a medical man.

This brief does not propose to go into the questions of freedom which are vital, but we do strongly urge that it is in the interest of this vast number of people that some such provision should be made; and we respectfully urge the committee to so report to the House of Commons.

On behalf of the Board of Trustees,
Human Adjustment Institute,
Vancouver, B.C.

B. MACDONALD,
Chairman.

O. W. SPENCER
Secretary.

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Canada Social Security
Office on, 1943

SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 18

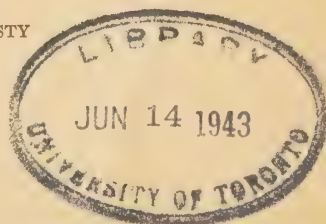
TUESDAY, JUNE 8, 1943

WITNESSES:

Mr. V. R. Smith, General Manager, Confederation Life Association.

Mr. W. M. Anderson, Asst. General Manager, North American Life Assurance Company.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

TUESDAY, JUNE 8, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman presided.

The following members were present:—Messrs.,—Adamson, Bourget, Bruce, Casselman (Mrs.) (Edmonton East), Claxton, Cleaver, Coté, Fauteux, Fulford, Gershaw, Gregory, Hatfield, Howden, Hurtubise, Johnston (Bow River), Lalonde, MacInnis, Mackenzie (Vancouver Centre), MacKinnon (Kootenay East), Macmillan, McCann, McGarry, McIlraith, Maybank, Shaw, Warren and Wood.—27.

The Chairman read a letter from Mr. Warren J. Maxwell, New Brunswick Optometrical Association expressing appreciation of the courtesy extended to the Optometrists during their appearance before the Committee on June 1st.

The Chairman also read a letter from Mrs. Anne E. Spencer, World Fellowship of Faith and Service, Vancouver, B.C. protesting against the power to be given the doctors under the proposed Health Insurance Bill.

On motion of Mr. MacInnis both these letters were ordered to be printed in to-day's evidence.

Mr. V. R. Smith, General Manager of the Confederation Life Association, was called on to introduce the other members of the Canadian Life Insurance Officers Association. He introduced the following:—

Mr. W. M. Anderson, Assistant General Manager, North American Life Assurance Company;

Mr. Bruce R. Power, Secretary and Actuary, Canadian Life Insurance Officers Association;

Mr. G. W. Bourke, Actuary, Sun Life Assurance Company of Canada;

Mr. S. C. McEvenue, General Manager, The Canada Life Assurance Company; and

Mr. H. R. Stephenson, General Manager of the Crown Life Insurance Company.

Mr. Smith and Mr. Anderson alternated in presenting their brief.

The Chairman having been called away Mr. McCann took the chair. The Chairman later returned and resumed the Chair.

The Appendix to their brief was not read but was ordered printed in the evidence.

The witnesses were examined and retired after the Chairman had thanked them for the evidence submitted.

The Committee adjourned at 12.30 p.m. to meet again Thursday, June 10th, at 11.00 o'clock, a.m.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 8, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Gentlemen, I have two letters for the committee. The first is from Mr. Warren J. Maxwell, of the Association of Optometrists of the maritime provinces, asking me to convey to the committee his sincere thanks and the thanks of those whom he represented for the courtesy shown to him and other delegates by the committee.

June 3, 1943.

Hon. CYRUS MACMILLAN, Chairman,
Special Committee on Social Security,
Parliament Buildings, Ottawa.
Dear Mr. Macmillan:

May I as representative from the maritime provinces, as well as on my own behalf, express thanks to you and your committee for the attentive and courteous hearing given us on Tuesday.

We appreciated your assurance that the brief of the Canadian Association of Optometrists (the national body), not read due to pressure of time, would be included in the record. I only regret that the same pressure of time prevented more than the briefest of meetings with yourself at the close of the session.

Yours sincerely,

(Sgd.) WARREN J. MAXWELL.

The second letter is from Mrs. Anne Spencer, International Secretary of the General Council of the World Fellowship of Faith and Service of Vancouver. I shall read the first paragraph only and ask your permission to put the letter on the record.

At a meeting of the executive council of the above body, I was directed to convey to you in the strongest possible terms, our protest to the proposal that treatments to be given to the sick as a benefit under the proposed social security measure, be exclusively the treatments of the medical profession.

Then follows certain reasons for that statement. With your permission this letter will be incorporated in the record.

Mr. McCANN: What is the organization?

The CHAIRMAN: The organization is the World Fellowship of Faith and Service.

Mr. McCANN: Is that a Canadian organization?

The CHAIRMAN: It is a world fellowship, a branch.

Mr. McCANN: At what point in the world did it start?

The CHAIRMAN: I would not know. I was probably not alive at that time. The branch is in Vancouver. Shall the letter go on the record?

Mr. MACINNIS: I so move.

The CHAIRMAN: Agreed.

WORLD FELLOWSHIP OF FAITH AND SERVICE

Tower Room, Vancouver Block,
Vancouver, B.C.

June 1, 1943.

Hon. CYRUS MACMILLAN,
Chairman of the Special Committee
of the House of Commons on Social Security,
Parliament Buildings,
Ottawa.

Dear Sir:

At a meeting of the executive council of the above body, I was directed to convey to you in the strongest possible terms, our protest to the proposal that treatments to be given to the sick as a benefit under the proposed social security measure, be exclusively the treatments of the medical profession.

We represent together with many other organizations, a large body of people who do not favour the use, at all times, of the therapies approved by the medical profession but who prefer to use the therapies advocated by the several branches of the natural healing profession, as well as the processes variously described as mental healing, spiritual healing, metaphysical healing or Christian Science.

We strongly urge that whatever report your committee makes to the House of Commons shall include the protests of those who oppose placing the citizens of Canada entirely in the hands of the medical profession so far as benefits under the proposed social security legislation is concerned.

Very truly yours,

(Sgd.) ANNE E. SPENCER.

Mrs. Anne Spencer, International
Secretary, General Council of the
World Fellowship of Faith and Service.

This morning we have representatives of the Canadian Life Insurance Officers' Association. Mr. V. R. Smith, General Manager of the Confederation Life Association will introduce the representatives.

Mr. SMITH: Mr. Chairman, Mr. Minister and gentlemen: This deputation is from the Canadian Life Insurance Officers' Association, and if I may I shall begin by introducing them to you. Mr. Anderson, Assistant General Manager of the North American Life, who is chairman of the social insurance committee; Mr. Power, who is Secretary of the Canadian Life Insurance Officers' Association; Mr. Bourke, Chief Actuary of the Sun Life of Canada; Mr. McEvenue, General Manager of the Canada Life Assurance Company; Mr. Stephenson, General Manager of the Crown Life Insurance Company. Mr. Chairman, if we may, Mr. Anderson will begin by reading a part of the brief, and if I may I will take up another part and he will come back at it again and I will finish. This will mean that the members will not have to listen to one voice throughout.

The CHAIRMAN: Thank you, Mr. Smith.

Mr. SMITH: Before I sit down may I say we would like to convey to Dr. Heagerty our congratulations on the honour that has just recently been paid to him in the King's honour list.

The CHAIRMAN: Mr. Anderson, please.

W. M. ANDERSON, called.

The WITNESS: Mr. Chairman, Mr. Minister and gentlemen, I should like to read first the letter of transmittal which is the preface to the memorandum we submit:—

On behalf of the Social Insurance Committee of The Canadian Life Insurance Officers Association, we have the honour to present to you the following preliminary submission. In doing so we express our satisfaction that your committee is giving consideration to the important problem of social security, of which the immediate subject under consideration is the proposed inauguration of public health and health insurance plans in Canada.

We appreciate the invitation to appear before you and the opportunity extended to us to contribute to your deliberations.

The Canadian Life Insurance Officers Association is a voluntary organization of the officers of the forty-eight Canadian, British and United States companies operating in Canada and representing upwards of 99 per cent of the total life insurance (excluding fraternal benefit insurance) in force in Canada.

In directing its attention as well as the skill of its members to the complicated social problems that lie ahead, the Association has been able to draw upon its studies over the past decade of several of the problems of social security, including unemployment insurance, health insurance and old age pensions, as well as its own experience in underwriting various types of insurance.

In addition, its close contact with and its financial support of public health programmes, and especially its interest in proper and adequate nutrition, and in better housing, have brought to its attention many of the basic economic and sociological aspects of the whole question.

These problems of social security involve the elemental but very complex relationships between millions of individuals of divergent viewpoints. It has been said that social security represents an equation between human nature in all its different aspects and basic economic factors.

Thus it will be seen that any programme of effective legislation requires coordination between many features of the whole structure which is becoming known in the popular mind as "social security." Our studies on all these points, extensive though they have been, have not yet progressed to the stage where a well rounded and complete review of the various aspects could be given. Nevertheless, when the invitation came to appear before your committee, we decided to accept and to state our views so far as they have crystallized. For the reasons which will appear in the preliminary submission herewith, we assume that your hearings will be resumed at a later date and that the Association will be given an opportunity to supplement and amplify this presentation in the light of changing conditions as the war proceeds, and in the light of our continued studies of the whole subject of social security.

From all this background of experience and observation the association hopes that the suggestions set out in this preliminary submission may be of assistance to your committee. In addition, may we state that in any respect in which we might be able to assist or cooperate, we would welcome the opportunity to be of service.

Respectfully submitted,

H. W. MANNING,
President

B. R. POWER,
Secretary and Actuary.

Mr. Chairman, I was talking to Mr. Manning on the telephone the day before yesterday and he asked me to convey his apologies for not being able to be present. As you know, his home is in Winnipeg. He was down here just within the last week and unfortunately could not remain. Mr. Smith will take over from this point.

V. R. SMITH, called.

A PRELIMINARY SUBMISSION UPON THE PROPOSED INAUGURATION OF PUBLIC HEALTH AND HEALTH INSURANCE PLANS IN CANADA

To the Chairman and Members,

The Special Committee on Social Security of the House of Commons.

The social insurance committee of The Canadian Life Insurance Officers Association welcomes this opportunity to present before the Special Committee on Social Security of the House of Commons the results of its deliberations on some of the many and complicated problems of social security, with particular reference to the proposed inauguration of public health and health insurance plans in Canada.

In the midst of a world-wide struggle for self preservation, and before the end is in sight, but in the confident faith that we shall emerge victorious with the unconditional surrender of our foes, we have gradually built up a conception of freedom upon which we have begun to lay the foundation of plans for a post-war world.

"Freedom from want" and "freedom from fear" have become the objectives of governments and peoples alike, not only in Canada but also in others of the united nations. With a view to achieving these objectives two proposals have been advanced:—

- (a) The abolition in peace-time of mass unemployment, and of unemployment prolonged year after year for the same individual; and
- (b) The inauguration and consolidation of social security plans for all classes, for all purposes "from the cradle to the grave."

Attention is drawn to the view of Sir William Beveridge that a satisfactory scheme of social insurance assumes the maintenance of employment and the prevention of unemployment. This does not mean "the abolition of all unemployment, but the abolition of mass unemployment, and of unemployment prolonged year after year for the same individual"; it means that his plan should of itself "have some effect in promoting the realization of this assumption." In the

fourth of five reasons given for saying that a satisfactory scheme of social insurance assumes the maintenance of employment and the prevention of mass unemployment the Beveridge report states in paragraph 440:

"Fourth, and most important, income security which is all that can be given by social insurance is so inadequate a provision for human happiness that to put it forward by itself as a sole or principal measure of reconstruction hardly seems worth while doing. It should be accompanied by an announced determination to use the powers of the state to whatever extent may prove necessary to ensure for all, not indeed absolute continuity of work, but a reasonable chance of productive employment."

Again in par. 443 the report states:—

The probable and the possible effects of the plan for social security in stabilizing the demand for labour are among its advantages and deserve to be noted. But their importance should not be exaggerated. They are subsidiary measures only; they do not touch the main problem of maintaining employment. For that other measures are needed. Unless such measures are prepared and can be effective, much that might otherwise be gained through the plan for social security will be wasted.

The purpose in drawing attention to the strong views expressed by Sir William Beveridge is to emphasize the point that, if any measure of health insurance is to be successful in reaching the objectives—

- (a) to provide a system of medical service directed towards the achievement of positive health, of the prevention of disease, and the relief of sickness; and
- (b) to render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional

then it must be constructed as part of a well coordinated and integrated scheme of social security based on the avoidance of mass unemployment.

We therefore urge that careful consideration be given to this point, to which we shall refer again, later, in this submission.

Consideration of Problems in Canada

There are other committees of the parliament of Canada interested in these inter-related problems, viz., the Special Committee on Economic Re-establishment and Social Security of the Senate, as well as the Special Committee on Reconstruction and Re-establishment of the House of Commons.

It would appear to be advisable that the proposals of all three committees should be coordinated in one complete and well integrated structure. Further, Canada has already enacted legislation in regard to several aspects of social security, for instance, unemployment insurance, old age pensions, mothers' allowances and workmen's compensation. All these were considered and enacted separately and constitute a group of heterogeneous legislative measures which could be more closely correlated with evident advantages. The desirability of such coordination and consolidation of similar measures in Britain was the principal reason for Sir William Beveridge's commission. It would be reasonable to expect that Canada would not want another separate legislative enactment, regarding one part of the social security structure, without planning the entire programme and making each part of the existing and proposed legislation fit neatly into the whole.

Views of the Association

With the inauguration and integration of well prepared and practicable social security plans for the maintenance of a minimum subsistence level for all classes, the life insurance industry is much in sympathy and will give its hearty support.

With the inauguration of comprehensive and efficient health and rehabilitation services we, as a life insurance organization, are also heartily in accord.

Just as in the United States, the partial plans of social security already set up have increased the demands for the services which life insurance companies have to offer, so too in Canada there may arise with the implementation of new social security measures increased demands for our services. Be that as it may, in the work¹ of the life insurance companies in the field of preventive health measures, in the field of nutrition in cooperation with the Canadian Medical Association, in the field of cancer research, and in dental and other activities, lies the evidence of our interest in plans of developing Canada and helping to make Canadians, from the standpoint of health and strength, education and intelligence, enterprise and initiative, second to none in the world.

"Thus we visualize the consolidation of existing health activities and the inauguration of comprehensive health and rehabilitation schemes. We support well coordinated and integrated plans to these ends and now proceed to make certain suggestions in this respect.

THE FIELD OF PUBLIC HEALTH

On the 27th of November last we filed with the advisory committee on health insurance a memorandum setting forth our views on the subject of public health. Under the circumstances it is unnecessary to review in detail the opinions expressed at that time since they have been published in the report of the advisory committee. However, we should like to emphasize the pre-eminent importance we attach to developments in the field of public health and the necessity for the elimination of the causes of sickness and disease. It would appear futile to arrange medical treatment for the individual to cure his disability and to return him to productive employment merely to have him become ill again. Every effort to remove the cause should be taken, for instance through better nutrition, the elimination of slums, improved housing, industrial hygiene, sanitation, health propaganda and educational efforts directed to the prevention of all disease.

The extensive experience of the companies in public health work has convinced them of the soundness of the view that any measures in the field of preventive medicine should be coordinated, but not consolidated, with a health insurance plan. We suggest that in no way should the inauguration of public health measures be contingent upon the inauguration of health insurance. Preventive measures of various kinds can and should be set up as fully and as completely as possible without waiting for the working out of the health insurance scheme. However, this is not to say that the effectiveness of public health preventive measures will not be buttressed and enhanced by the introduction of health insurance. In this respect may we say that we concur that the full objective of preventive measures cannot be attained until the practising physician becomes in effect a public health officer in respect of the families for whose health he is responsible.

Wartime Personnel Problems

We are influenced in our views in this respect by the fact that the provision of medical care probably cannot be implemented till the war's end. A large number of our doctors, dentists, nurses and other personnel auxiliary to these professions are in the military service of the nation. Many of us no doubt have felt in our own families the impact of the marked reduction in the civilian supply of these services.

¹ An appendix is attached listing the health activities to which the life companies have contributed the time, the energy and the talents of their officers, as well as financial assistance of many hundreds of thousands of dollars.

Then, too, a large part of the medical, dental and nursing professions—especially those who have gone directly from professional training into the armed forces—may have become accustomed to conditions of service which are economically and otherwise quite different from those of private practice in peacetime. What will be their attitude after demobilization and they and their military, naval and air clientele return to civilian life?

Reference will be made later in this submission to the necessity of training expert administrative personnel, which is not now and probably will not be available till after the war is over.

This shortage of manpower, as well as the present difficulties of administering existing hospitals and the probable acute shortage of hospital accommodation until after the war, gives an opportunity for further discussion and analysis of all these proposals both for preventive health measures as well as the setting up of a health insurance fund. We stress this point because inability to meet promised benefits would surely lead to a widespread disillusionment and there is no greater danger to a democracy than a disillusioned people.

These difficulties need not delay the perfecting of the plans and the consequent enactment of legislation in respect of health insurance through the implementation of the plan itself should be delayed.

Mr. Anderson will read the brief from here.

Mr. ANDERSON (Reads):

HEALTH INSURANCE PROPOSALS OF THE ADVISORY COMMITTEE

With respect to the health insurance proposals made by the advisory committee, we first wish to point out that the committee's report has only become available to us within the last few weeks. Therefore our observations must necessarily be of a somewhat general and tentative nature, rather than of the detailed character which we should prefer them to be. In addition, we have had little opportunity for a full discussion within the association of the problems involved. Nevertheless we believe that we are expressing the views of the majority of our members.

1. Governmental Responsibility in the Field of Medical Care

In considering the proposals in respect of medical care, our first concern has been whether greater government activity in this field is necessary and desirable. We believe that this is the case, since the present system has proven inadequate in certain respects. For example:—

- (a) The medical care of indigents has been unsatisfactory both by reason of its insufficiency and the unfairness with which the financial burden has been distributed.
- (b) Among the low per capita income groups, *i.e.*, where wages are low or the number of dependents high, the cost of medical care has prevented complete service and has jeopardized the economic solvency of many families.
- (c) In sparsely populated sections, the cost of providing adequate service is often beyond the capacity to pay of such communities.
- (d) The practising physician, in general, has had insufficient opportunity to devote his time to those preventive measures which he alone can carry out to best advantage.

We should like to emphasize again, however, that the development of adequate treatment services of every kind may be a slow process, since it depends upon the expansion of the body of technical personnel and upon major capital expenditures. In both respects the immediate postwar period would seem to offer the best opportunity to make substantial progress in this direction.

2. *Method of Financing the Provision of Medical Care*

The question naturally arises as to whether a plan for the provision of medical care should be financed by the state from general taxation or supported by contributions made by the individuals benefited. We are strongly in favour of a plan supported by specific contributions made by the individual for the purpose of defraying the costs of the benefits provided. We believe that as a general rule the state should avoid embarking upon plans involving permanent large-scale expenditures to be provided from general revenue sources. In addition, we believe that the individual welcomes the opportunity to contribute to the cost of any form of social insurance, because he wishes to be a partner in the plan—not simply a beneficiary—and because he knows there is little justification for the introduction of a means test for benefits if he has been sharing directly in the cost. Furthermore, it must be remembered that in the initial stages it may be impossible to attain to the same standards of service in all parts of the country at one time, and a flexible contributory system might possibly be necessary to preserve equity in such a situation.

3. *Health Insurance Contribution Method*

In considering the individual's method of contribution to a health insurance plan, we believe that, within the limits of practicability, his contribution rate should be commensurate with the cost of his expected benefits.

The advisory committee's illustrative rate of \$26 (or more accurately \$26.45) represents the assessment of only five-sixths of the cost of expected benefits (*i.e.*, \$18 per capita for the whole population) spread over the population aged 17 and over, the remaining one-sixth being provided by dominion subsidy. Our recommendation that the contribution level should be related to the full expected operating cost would result in a comparable contribution rate of about \$31 or \$32.

To place the contribution at a lower level would mean a subsidy on the part of the state or employer, which is always difficult to justify in theory and which in practice is open to continued pressure for change in amount. On the other hand, direct contributions by the individual at a higher level than that of the expected benefits would impair the insurance character of the plan, and again would leave the way open for an infinite variety of changes in the incidence of contributions. However, the principle of pooling the costs in respect of children within the adult contribution rate appears to be not only a socially desirable and progressive recommendation, but also one which merits a high degree of popular acceptance.

We wish to emphasize that the individual rate of contribution should not necessarily be fixed for long periods of time. It is a rate which is primarily dependent upon six factors:—

- (a) The proportion of children within the insured population.
- (b) The invalidity rates experienced and the changing pattern of age, sex, occupation, etc., upon which such rates in part depend.
- (c) The extent and quality of medical care which it is possible to provide.
- (d) The methods of remuneration of technical personnel, *e.g.*, the fee, capitation and salary systems which may involve substantially different costs.
- (e) The scale of fees, salaries, etc., which are used.
- (f) The administrative care exercised in the handling of claims.

As between different insured groups the rate of benefit costs incurred may vary substantially and, theoretically, the rate of contribution might also vary according to the risk involved. Such a procedure is often a necessity in private insurance in order to guard against adverse selection resulting from the non-

entry or withdrawal of the better risks. It is fraught with difficulties, however, in defining the risk classes and the relative contribution rates and can result in no more than very rough equity, since the variation in risk within any definable class may substantially exceed the difference in risk as between classes. While such a refinement may be theoretically desirable, it is not a necessity in a compulsory plan, and accordingly we believe that, at least in the initial stages of health insurance, the rate of contribution should be a flat amount for all persons in respect of whom contributions are contemplated.

It is appreciated that, because of the various factors involved, it is impossible to forecast with great accuracy the proper contribution level. The \$26 contribution rate used by the Advisory Committee is based upon the assumption of medical care costs of \$21.60 per capita per year. Our understanding is that this figure is intended to represent the cost under the existing system of supplying medical care. It may change materially if medical care is supplied under a health insurance plan.

We believe that the best possible forecast of the cost of medical care under compulsory health insurance should be made by employing fully the best available information and techniques. We are sorry that the advisory committee has not indicated its views as to the methods which should be followed in making such a forecast. In addition, if the \$21.60 per capita figure is not merely a tentative estimate, we should be much interested in learning of the methods whereby it was derived. The basis of estimating cost is, in our opinion, not only important initially, but also should be used periodically thereafter to change the contribution rates in such a way that they continue to reflect the most up-to-date information as to the cost of providing benefits under the plan. Only in this way can the financing programme be kept on an equitable and non-controversial basis.

4. Persons with Inability to Pay Full Contributions

In the case of those who are unable to pay the full rate of contribution prescribed, we have noted with great interest the advisory committee's proposal whereby a limiting rate of contribution is set as a percentage of the individual's income, with the deficit made up by the employer in the first instance, otherwise by the state. This method produces a homogeneous system without anomalies, extending from the indigents at one end of the economic scale to those with ability to pay the full contribution rate at the other. There is a uniform contribution in respect of everyone, with the employer or state taking up the slack where full ability to pay does not exist.

On the other hand, it has seemed to us inconsistent and inadvisable that the method of dealing with cases where full ability to pay is lacking should be made part of the health insurance legislation itself. The existence of inability to pay is a social and economic problem which seems to be independent of and more far-reaching than the health insurance plan as such. Would it not be preferable to provide a compulsory uniform contribution rate within the health insurance plan, and then by suitable separate legislation to deal with the mechanism whereby all or a portion of the contribution is made up in those cases where full ability to pay does not exist? In our opinion such separate legislation would completely remove from the field of health insurance a problem which is of a different character and foreign to the task of providing adequate medical care. In addition, this same separate legislation, which might be termed, for example, a "Social Insurance Assistance Act," could quite properly be used with respect to other phases of social insurance which might otherwise require modification because of inability to pay.

Because of the foregoing suggestion and its implications, we feel that it is inappropriate at this time to present any comments on the particular percentage rates of contribution suggested by the advisory committee in respect of the

lower income groups. In addition, and for the same reason, we refrain from comment on the proposal that the employer should bear a share of the cost in the case of the low wage groups, although we are inclined to the view that the employer should not be required to make such contributions for health insurance purposes.

5. *Governmental Financial Burden*

In making suggestions as to the administration of plans of social security, it is impossible to disregard the governmental financial burden and the consequent constitutional questions which may arise. It is quite likely that the British North America Act, 1867, will, at least in some measure, be revised following the war's end. We suggest that consideration be given to the desirability of obtaining the necessary constitutional amendments to the end that the financial structure of all social insurance plans be made a federal responsibility. In no other way will it be possible to distribute equitably the economic burden as between provinces, and to obtain co-ordination between the various portions of the social security programme, which co-ordination is so desirable and indeed so necessary if the utmost in efficiency is to be attained.

Under this suggestion, the health insurance fund would become a federal responsibility along with the unemployment insurance fund. On the other hand, we concur in what appears to be the general opinion, that the provinces should retain administrative responsibility for the provision of the health insurance benefits and that they, along with the municipalities, should be responsible for carrying out many of the measures of a preventive nature, such as adequate and proper nutrition, better housing, sanitation, educational and other activities for the improvement of health. The dominion government might assist in these efforts of the provinces by giving advice and guidance, by lending the services of expert federal personnel, and by the judicious use of limited grants-in-aid for the purpose of stimulating provincial action.

The advisory committee's illustrative proposal for financing health insurance involves providing each province with a fund consisting of (a) a federal per capita grant together with (b) the individual contributions from its own citizens, which on a per capita basis vary with the proportion of children and with the degrees of ability to pay existent within the province.

The province becomes financially responsible for making up the difference between the fund thus provided and the operating costs of the plan, together with the administrative costs in respect of both the collection of contributions and the provision of medical care. The provincial burden is not only large but, as between provinces and from year to year, is substantially affected by the extent of inability to pay existent in each province and the proportion of children in each provincial population. One of the most disturbing features of this arrangement is that the provinces in which the burden would be relatively high would be the very provinces least able to meet such a cost. Even the alternative proposals of dividing the financial cost as between Dominion and provinces fail in large measure to correct this situation. Indeed, the question arises whether several of the Provinces could afford to implement the health insurance plan on any of the financial bases so far proposed.

We have suggested a method whereby there would be federal provision in the form of separate legislation to cover deficits resulting from inability to pay. Under the federal health insurance legislation itself, we suggest that the full contributions form a national fund, out of which payments would be made to the provinces on a per capita basis. The provincial burden thus would be only the difference between a constant per capita revenue and the actual operating

and administrative costs of medical care within the province. It would not be affected by the degree of inability to pay on the part of the contributors, nor by the proportion of children in the provincial population.

To summarize, the present proposal visualizes nine different insurance funds, with provincial financial burdens varying inequitably as between provinces and sensitive to economic changes which are beyond provincial control. We suggest one national insurance fund under federal financial responsibility and control, but with full responsibility for the administration of health insurance benefits in the hands of the provinces without any embarrassing financial burdens. We further suggest that the necessary steps be taken to obtain an amendment to the British North America Act, 1867, to this end.

6. *Limitation of the Insured Group According to Income Level.*

We have noted that it will be possible for a province to set an upper income level above which the health insurance plan will not be applicable. There is a difference of opinion among ourselves as to the desirability of such a provision, and without expressing any view on this point we should merely like to mention several problems which may arise if there is a limiting income level for the plan:—

(Hon. Mr. Macmillan, chairman resumes the Chair.)

- (a) The satisfactory definition of a covered group within a larger community is difficult from the point of view of administration.
- (b) An illogical inconsistency can arise between the individual just inside the insured group and the one on the other side of the border line.
- (c) Certain persons would, from time to time and even frequently, pass from insured to uninsured status and vice versa, and in the case of health insurance this would prevent the continuous long-term coverage which seems so desirable, as well as adding to the problems of administration. It may be noted that already an amendment to the Unemployment Insurance Act is under consideration because of this particular situation.
- (d) In so far as the health of the individual is affected by the health of his fellow citizens, the success of health insurance may be impaired by the intermingling of insured and uninsured individuals.
- (e) With all children insured, the fact that those parents above the limiting income level would not contribute might appear illogical and cause dissatisfaction.
- (f) A compulsory plan applicable to certain groups alone may result in a legitimate demand for administrative responsibility to rest within the body of insured persons, with the result that the services of persons with highly developed technical and administrative abilities might not be available.

I should like Mr. Smith to continue from here, Mr. Chairman.

MR. SMITH:

CONCLUSION

The end of the war will bring to Canada many economic problems, not the least of which will be those relating to taxation, budget controls and the revision of the financial relationships between the provinces and the dominion. Upon the skill with which these are solved will depend, in a large measure, the successful solution of the most urgent problem of all—the avoidance of mass unemployment. Accordingly we have suggested that the measures taken to build in Canada, upon firm foundations, a social security structure which includes the provision of adequate medical care to the Canadian people must be measures which fit into

the national economy. We assume therefore that the economic and financial advisors of the government will, in due course, report on these features of the various suggestions before you. May we assume that these reports will be published, together with other specialized reports, upon which your conclusions will be based?

We visualize that the consolidation of public health preventive services and the establishment of a health insurance fund contemplate the contribution of the knowledge and the talents of many professions. The services of them all must be utilized: the social welfare worker to plot the general pattern of what is required; the doctor, the dentist, the nurse and others engaged in the protection and preservation of the health of the people to advise on the general methods of operation; the statistician to interpret the record of the varied and complex statistics of Canadian life; the actuary to examine the costs and the steps necessary to avoid the distortion that may easily arise if the financial measures and varied benefits are not in harmony; and finally, the economist to make certain that all measures fit as a compact part into the entire national economy.

Canada's financial and economic methods in fighting a world-wide war have received high praise in many quarters. They have been brilliant in conception, sound in principle, and well-nigh perfect in their timing. It is our confident hope that with the unselfish support of all the interested professions it will be possible to do in Canada what has not yet been successfully achieved in any country, i.e., a comprehensive plan of setting up a health insurance fund for the establishment of adequate and efficient medical care for every individual in the nation. If this be done, Canada will achieve, in a new and complicated field, the high prestige which it has already won in the field of war finance and economic controls and stability.

We conclude by repeating what we said earlier:—

With the inauguration and integration of well prepared and practicable social security plans for the maintenance of a minimum subsistence level, for all classes, the life insurance industry is much in sympathy and will give its hearty support.

I want to make one further observation. We have attached to the brief an appendix. If we may, Mr. Chairman, we should like to have it included in the report.

The CHAIRMAN: Yes.

Mr. SMITH: I shall not read it, but I should like to point out one thing, that it is curious that we began work in the field of preventive medicine, if you would like to call it that, and preventive health work about 1925, and the first major project to which we devoted a tremendous amount of time, energy and financial assistance was in the maritime provinces. The idea was sold to us by Dr. Wodehouse, then executive secretary of the Canadian Tuberculosis Association, now the Deputy Minister of Pensions and National Health.

APPENDIX

SUMMARY OF THE ACTIVITIES OF THE CANADIAN LIFE INSURANCE OFFICERS' ASSOCIATION IN THE FIELD OF PUBLIC HEALTH AND NUTRITION

Public Health

Cooperative public health activities were commenced by a group of member companies of the association in 1926, after some three years of investigation and planning, and, during the intervening years, grants aggregating well over half a million dollars have been made to various organizations. Participation of companies is entirely voluntary and at the present time the group is composed of 24 Canadian member companies, representing 98.5 per cent of the premium income in Canada of all Canadian member companies.

This work has been carried on through a Standing Committee on Public Health and has been directed, broadly speaking, toward the financial support of organizations which have for their object the improvement of the general health of the people with particular emphasis on tuberculosis, control and treatment, child welfare, dental health and health education. Among the conditions upon which the support of any project is contingent are the following:—

- It must be educational in nature.
- It must be guided by a responsible organization.
- It must be of national importance.
- It must be designed to become self-supporting.

The following is a brief summary of the major grants which have been recommended by the committee and approved at the annual meetings of the association:—

1926-43—Canadian Tuberculosis Association for special campaigns conducted in the Maritime Provinces, Prince Edward Island and Quebec, and for expansion of its educational facilities throughout Canada.....	\$229,550
1927-43—Canadian Dental Hygiene Council for campaigns conducted in every province of the Dominion	115,150
1928-43—Canadian Welfare Council, chiefly to defray expenses in regard to pre-natal and post-natal letters.....	122,750
1928-37—Canadian Medical Association for newspaper health articles.....	53,000
1934-43—Canadian Public Health Association for its general work, the aim of which is to strengthen and improve local health services and to stimulate community interest in public health	25,500
1935-40—King George V Silver Jubilee Cancer....	50,000
1940-43—Health League of Canada.....	25,000
1938—National Committee for Mental Hygiene. Study of the distribution of medical care and health service in Canada.....	5,000

The assistance thus rendered has, of course, been insufficient to deal with more than a minor part of the national problem, but the funds made available demonstrated conclusively the very definite benefits to be derived from public health measures. The association has consistently followed the policy of helping organizations to carry out specific programmes until they become self-supporting or until the success of the project has made it possible to obtain financial support from governmental or other sources.

The following illustrations may be of interest in this connection:

Tuberculosis.—In 1925, Dr. R. E. Wodehouse, O.B.E., now Deputy Minister of Pensions and National Health and then the Secretary of the Canadian Tuberculosis Association, was instrumental in interesting the life insurance companies in their first major undertaking in the public health field. It was at this time that the association lent its support to a five-year campaign for

the control and treatment of tuberculosis in the maritime provinces. This campaign and the subsequent campaigns conducted in Prince Edward Island and Quebec aroused the interest of the provincial and municipal authorities and of the public generally. These provinces had had the highest death rate in Canada and facilities for the treatment of tuberculosis were particularly lacking. In every instance sanatorium and clinic facilities have doubled as a result of the campaigns conducted and the death rate has declined steadily.

In New Brunswick and Prince Edward Island permanent organizations are now carrying on the work initiated with the funds made available by the life insurance companies. Out of the Prince Edward Island demonstration in the years 1931 to 1936, which was a joint undertaking with the Red Cross Society and the provincial government, grew the Department of Health and the tuberculosis service in their entirety. A striking example of the results which may be accomplished is found in the following figures for New Brunswick—

Average death rate from tuberculosis

for the year 1925:	103	per 100,000
for the year 1930:	96.5	per 100,000
for the year 1935:	78.1	per 100,000
for the year 1940:	65.3	per 100,000

Dental Hygiene.—Grants made by the Canadian Dental Hygiene Council for provincial campaigns, out of funds made available by the life insurance companies, are contingent upon a grant of equal amount being made by the provincial dental association and upon a considerably larger grant by the provincial government. Consequently the council each year promotes an expenditure for public dental health educational services several times the amount of its own budget.

From the time the first grant was made by the association the council systematically endeavoured to carry out each year an extensive mouth health campaign in a province where mouth health had not previously been included in its regular programme. By 1937 a campaign had been conducted in each province of the dominion. The council's object is to have such programmes become part of the permanent health programmes of each province and with this end in view organization and supervision assistance is continued in all provinces. It is of interest to note that whereas in 1932 only one provincial health department in Canada (Ontario) had an organized dental health programme, to-day in every province but one, through the efforts of the Canadian Dental Hygiene Council, definite grants are included in their budget for this work, and effective programmes based on well established principles that have been developed to safeguard the public are being carried out.

Maternal and Child Hygiene.—The annual grants made by the association to the Canadian Welfare Council since 1928 have been earmarked for the purpose of defraying expenses in connection with the pre-natal and post-natal letter series issued by the council. Distribution of this literature has been made largely through the provincial health departments and arrangements whereby the cost thereof will be borne by the provincial governments are at present in process of completion.

Nutrition

Five years ago the executive committee of the association appointed a Special Committee on Nutrition whose members serve on a Joint Committee on Nutrition with representatives of the Canadian Medical Association. A

special committee was named to deal with matters relating to nutrition because the proposed work in this field differed from the ordinary public health activities of the association and was in the nature of an experiment. During the intervening years the participating companies have voluntarily expended on nutrition projects sponsored by the joint committee for booklets, posters, speakers, special courses, etc. (including projected work) approximately \$100,000. The latest venture, a new 16-page booklet in colour entitled "What They Eat to be Fit," based on the motion picture "Training Table," prepared by the medical branch of the Royal Canadian Air Force to educate airmen and airwomen in the "whys and wherefors" of what to eat, is just off the press. The first edition will run over a million copies and it is the hope of the committee that a copy will ultimately find its way into the 3,000,000 homes in Canada.

The CHAIRMAN: Thank you.

Mr. WOOD: Was the introduction of that scheme of health improvement done for the purpose of protecting the premiums invested in the company?

Mr. SMITH: May I tell you a little story? A short time ago we were showing some films and giving some lectures with regard to the advantages of nutrition. Some person said, "That is just a lot more of life insurance propaganda designed to protect their own interests"; and the chap replied, "I think you have something there." But after all they are trying to have you and me live a little longer. Perhaps we are making a mistake.

The CHAIRMAN: Are there any other questions?

Hon. Mr. MACKENZIE: In regard to your financial suggestions in this brief, what would be the exact nature of the provincial contribution? You have one national insurance fund established and the administration left with the province; what contribution financially would the provinces make under the suggestions contained in this brief?

Mr. ANDERSON: Mr. Minister, assuming that the medical care costs in the provinces were as suggested by the advisory committee, let us say, of the order of about \$24, including administrative costs, the suggestion that we have made would be that the national fund would supply the provinces a per capita amount, which might be of the order of perhaps \$20, \$21, \$22, practically the whole cost. That would be a constant per capita revenue of the provinces. The provinces would have to meet only a very small margin; but of course they would have the full responsibility if they let those administrative costs get out of hand.

Hon. Mr. MACKENZIE: Would they pay for the administration themselves under your scheme?

Mr. ANDERSON: Yes.

Hon. Mr. MACKENZIE: Practically the entire cost of the scheme would be borne by the federal treasury?

Mr. ANDERSON: As we envisage it, the grant from the federal fund would amount to somewhere around the level of 90 or 95 per cent of the total cost of running the scheme in the provinces. The margin that the provinces would pay would be extremely small, but then the provinces would be responsible for anything that happened if they let those administrative costs get out of hand. If they let those costs go up too far through maladministration that would be a provincial responsibility. In other words, the grant they receive from the federal fund would be on a fixed per capita basis designed to cover 90 or 95 per cent of the total cost.

Hon. Mr. MACKENZIE: In essence there is not much difference between your suggestion and that which we had from Mr. Garson the other day, on the basis of an adjustment grant.

Mr. ANDERSON: No, except for the fact that by this method the dominion government would not have to dig down into the provinces' finances to find out whether or not there was a question of physical need. That is, the financial burden of any province is merely administrative.

Hon. Mr. MACKENZIE: Your scheme practically amounts to this: the provinces administer all but give little?

Mr. ANDERSON: Yes.

Mr. SHAW: On page 9 reference is made to the ability or inability to pay. I understand that the speaker—and I notice it in the brief—advocated a social insurance assistance Act to assist in meeting the cost which cannot be met by those in the low income bracket. You would not envision, of course, the drawing of a line between those who have the ability to pay and those who are not able to pay the full amount, would you? They would be all treated the same and the social insurance assistance Act would make up any deficiency which could not be met by the individual. In other words, I would be very much opposed to placing these people in two groups, those who are able to pay and those who are not. I think it would be dangerous.

Mr. ANDERSON: I think this contemplates everyone paying exactly the same amount and within the Health Insurance Act there is no distinction between an indigent and a person partially able to pay and a person able to pay in full. It envisions, however, an insurance Act which would be common not only to this measure but to the other measures that will be brought forth in due course for a complete social security scheme, so that those who are indigent or who cannot pay can apply under the other Act and obtain whatever amount is necessary to pay into this. There is no means test.

Mr. SHAW: I think my fears are more or less confirmed. I believe you have indicated the individual who is not able to make his full contribution because of economic circumstances over which he has no control will have to make a separate application for assistance. I think that is dangerous. I fancy it would be much better if we could calculate the deficiency, the cost of the low income groups; that if that were made up by the government, as I think it would have to be, it will not place the responsibility upon those individuals—who, because through no fault of their own, find themselves in a certain financial position—of making an application for special assistance. It sounds too much like the old system of relief.

Mr. ANDERSON: I think under the present Act if a man is unable to pay \$26—I think it is 3 per cent—he is relieved of that amount. Now, we will be relieved of any amount in excess of 3 per cent of his income, but less than \$26, and that difference then will be obtained from this Act and paid into this fund. I do not think that is anything more than you already propose under your present scheme.

Mr. JOHNSTON: There is just one point on the third page that I should like to refer to. The speaker referred to Sir William Beveridge's report and I take it these are his own words. In the third line he says: "This does not mean 'the abolition of all unemployment, but the abolition of mass unemployment, and of unemployment prolonged year after year for the same individual'; it means that his plan should of itself 'have some effect in promoting the realization of this assumption.'" I do not understand what you mean by "mass unemployment." I take it if there is unemployment, no matter in what degree, unless it is the individual's own negligence that brings about the unemployment so far as he is concerned, the social security plan should be responsible for it; that any unemployment which is caused by economic conditions over which the individual has no responsibility should be a definite charge upon the social security scheme or those responsible for its functioning. Would you explain that?

Mr. ANDERSON: I think the answer, Mr. Chairman, is that the phrase "full employment" is often misunderstood. I think it was mentioned in this committee that $8\frac{1}{2}$ per cent or 10 per cent might be the maximum mass unemployment that might be referred to as not, shall we say, too much out of the way. There is no question in our minds that if the mass unemployment were, say, 30 per cent or even more, it is still the responsibility of the Unemployment Insurance Act or whatever measures you may have under the social security scheme; but if you have a large measure of unemployment all these schemes will break down. In that case what you would be doing really would be sharing of poverty rather than the sharing of the abundant things of life. Therefore, we are urging that in planning this measure due regard must be had to the other measures that must be set up to make it work. Does that explain it?

Mr. GERSHAW: In clause 2, at the bottom of page 7, it is suggested that every individual who is able to pay his way should do it. It is even suggested there that the full cost of \$31 to \$32 should be paid by each individual. It seems to me that in some cases people who are trying to get along and working hard might find it a very great burden on them. I should like your opinion as to how this amount is going to be collected. Suppose there is a family of five or six adults and there comes a time when they do not pay up, how are you going to collect it, and are there any other reasons why the ability to pay should not be taken into consideration?

Mr. ANDERSON: On the first point, Mr. Chairman, the question of methods that you would use for collections, we did not bring it out in our statement, but we are very much worried about that ourselves. We are worried about the suggestion that the provinces should have to build up and maintain this whole collection system. They have no facilities to-day for making collections of this kind. The dominion at least has two sets of machinery, the Income Tax Act and the Unemployment Insurance Act, which are highly developed collection systems, and they extend over a very large portion of the population. It is true they do not extend over the full population, and it may be that the only way that we can deal with the residual population is by the suggestion that has been made that we reach down into the municipalities and use them as an instrument for the collection from people who would not otherwise be required to pay under the machinery. On the second point we feel that the suggestion that the advisory committee has made as to an automatic method of determining how much a man can pay in the lower income levels, with an arrangement for carrying that up to higher income levels in the case of people with adult dependents, is an extremely good one. We are not quarrelling with the effect of that suggestion on the individual. We would be quite satisfied to see the individual left in about the same position in those lower income groups as the advisory committee have suggested. We would be quite satisfied under the proposed social insurance assistance act to let it have a formula of that kind that would determine the limiting rate of contribution that an individual would make and that would provide for automatic provision of the balance between that and the full contribution rate that is required. As far as the individual is concerned his position would be no different, his attitude towards the legislation would be no different than from what it would be in the advisory committee's proposal.

Mr. GERSHAW: Would his benefits stop if he did not pay?

Mr. ANDERSON: I have asked myself that question a number of times. If he could not pay his benefits should not stop because your scheme does not contemplate him paying if he cannot pay. If he evades paying do you suppose he should get benefits.

Mr. SHAW: Still it would jeopardize the whole scheme if a fairly large percentage, say even 10 per cent, failed to make contributions?

Mr. ANDERSON: Yes; that is why it seemed to us important that we should use the most effective machinery we have developed, that is, our income tax procedure with its very widespread source deduction system, and the Unemployment Insurance Act that has an even more widespread method of collection.

Mr. SHAW: That is one reason why I have always had a tendency to lean towards a non-contributory scheme. I think when it comes to the means of collection under a set-up like this where you go to the individual and designate that you are going to collect a specific amount for that purpose you are going to run into this and numerous other difficulties. The speaker has already indicated that through some scheme such as the income tax machinery you should have far less difficulty. That is what I have had in mind right from the beginning when considering contributory versus non-contributory insurance.

Mr. JOHNSTON: May I support what the hon. member has just said? I notice in the report that the Canadian Life Insurance Officers Association agrees with a plan whereby the beneficiary will pay part and then the employer will pay a portion. Since this whole thing is based on an economic problem, and as our desire is to improve the health of the individual and the nation as a whole, it seems to me that when you ask the employer to contribute a portion of this the employer will immediately place his share in the cost of production and that immediately raises the cost of consumer goods. That in return lowers the standard of living for the individual which in turn impairs that individual's health, especially if he happens to be in a low income bracket. I believe we are defeating our very purpose there when we suggest that the employer should contribute a portion of this. Everybody knows he will include it in his price. He cannot do otherwise, and I am not blaming him for it, but it seems to me that in an indirect way we are going to defeat the very thing for which we set out, that is, to raise the standard of health. I am more inclined to agree with Mr. Shaw that it should be put on a non-contributory basis where everybody will have access to this health insurance.

Mr. SMITH: May I reply by pointing out that on page nine at the end of the second paragraph we state we have not examined this idea in detail, but that we incline to the view that the employer should not be required to make any contribution.

Mr. JOHNSTON: I am glad that you pointed that out. I agree with you there.

Mr. SMITH: We are very clear on that. I think if you look at the amount that is to be collected from the employers it is not a large amount in total in this scheme, but as to whether there should be a contribution method or not that is really a problem in psychology. I submit for your consideration that the ordinary citizen prefers to have something for which he is paying a part himself and not something which is given to him by that impersonal organization known as the state, and that he will then resent—a view in which we concur—any means test.

Mr. SHAW: You would agree, however, that the word "non-contributory" is really a misnomer. I have noticed that various speakers in presenting briefs endeavoured to convey the impression that because you do not make a contribution directly for that purpose that you are receiving something for nothing. Any of us who are taxpayers in Canada know that is not the case. Actually "non-contributory" is a misnomer because you would be paying taxes anyway. On the basis of ability to pay you would be paying for the services which you would acquire. I think we should not even use the term "non-contributory" in the sense we have been using it.

The CHAIRMAN: Any other questions?

Mr. JOHNSTON: I would like to ask the speaker why he has stated very definitely they are not in favour of the employer making a contribution?

Mr. SMITH: Please, we have not stated it definitely, although we are inclined to the view, but we have not had time to analyse this. Remember we have only had this telephone book, shall we call it, a few days and we have not had a chance to really go through that with any fine tooth comb of thinking and reading. Neither have we had a chance to analyse the views of all our members, but we put forth that suggestion because the committee itself was inclined to the view the employer should not be asked to contribute. Perhaps, Mr. Chairman, we will develop that a little more fully if we are permitted to appear again before the committee.

Mr. HOWDEN: I am not at all clear with regard to the working of this social insurance assistance act which is suggested. I should like the witness to point out or define the difference between the application of the social insurance assistance act to make up the deficiency in premiums and the method in which the federal government is now doing the same thing? What difference would it make in the end?

Mr. ANDERSON: We have felt that a plan that will provide essentially a flat benefit such as medical care should more logically be financed in the first instance by a scheme which will provide flat contributions by the individual. That is the \$26 or \$30 or \$32 rate that has been suggestion. Obviously, when we come to the point of those who face inability to pay we must do something about them. It is desirable that they should be insured, and yet they cannot pay a flat premium for a flat benefit.

Mr. HOWDEN: The federal government is doing that in any case.

Mr. ANDERSON: It is doing it, or rather let us say the state, either federal or provincial government, is doing it in one way or another, and is perhaps doing it under the surface. Our feeling is that those problems resulting from inability to pay should be faced frankly and openly. They should not form a part of a single piece of social insurance legislation. They should be dealt with together as an integrated problem where it would be in the public accounts as to the amount that had been required for the direct purpose of providing those deficits in contributions resulting from inability to pay and where, if necessary, we can turn around and provide that money by the method that the hon. member has suggested of a special charge within our general taxation. I think that many of us, who are perhaps in the fortunate position of having some degree of ability to pay, would be very happy to pay a special tax that was designed particularly for the purpose of providing revenue for such a social insurance assistance Act in order to meet those deficits in contributions that occur with respect to our less fortunate fellow citizens.

Mr. HOWDEN: Would you say that is not very much what will happen anyway, that those deficiencies will be made up by the state, as you say, whether it is the provincial or federal state? Does it not amount to the same thing in the end?

Mr. SMITH: May I answer the question?

The CHAIRMAN: Yes.

Mr. SMITH: I think what the device is intended to do is to redistribute the burden between the provinces and the dominion. The provinces' ability to tax is restricted. This device throws the burden of the indigent and those who are partially able to pay on the federal government. You will find under this arrangement when it is analysed that the contribution of the federal government instead of being about \$40,000,000 as it is under this present scheme will be quite materially increased, a very substantial increase. Our feeling is if this scheme goes through as it is it will throw such a burden on the provinces that many provinces who are unable to stand that load will not be able to implement the Act at all. I think that is a point that has not yet been analysed with a great deal of care. I understand the advisory committee have some studies

under way but those have not been published. Therefore we have not criticized that in detail. We have raised the point and it is a very important point. It is another reason why in our conclusion we are suggesting that the whole arrangement, both of this Act and the other Acts which are to come under social insurance schemes, will be reviewed by the financial advisors and the economists of the government because they have got to fit into the economy as a whole. That, gentlemen, I think you will agree means the various arrangements between the provinces and the dominion.

Mr. HOWDEN: With the bill as it is drafted at present can that matter not be arranged? Can that matter not be coordinated in the draft of the bill at present?

Mr. SMITH: We are very doubtful of that.

The CHAIRMAN: Any other questions, please?

Mr. McCANN: What is your objection to a means' test? There is a great deal of difference of opinion with reference to inability to pay. In a great number of instances I think it may be interpreted as unwillingness to pay. You must have some yardstick of measurement whereby people would not be left free of any of the obligations under the Health Insurance Act; you have got to have some sort of test other than the person's say-so that they are unwilling to come in under the scheme, because as I say it is very often unwillingness to pay rather than inability.

Mr. SHAW: Would not the same principle used in connection with the income tax levies solve that problem? Over a certain income they are regarded as having the ability to pay; under a certain income they are regarded as not having the ability to pay. I think that is a fair enough test.

Mr. ANDERSON: It is very difficult to take some particular income and say that over this income you can pay and under this income you cannot. In the first place it is extremely difficult to draw a line for all different people, and in the second place that might create a substantial anomaly if the contributions became high. For instance, we are talking about a \$26 contribution rate. Perhaps you might draw the line there and say up to such and such an income you have not got the ability to pay it. Supposing you have several other social insurance measures with the combined premiums for all of them getting up into a pretty substantial sum of money; you could not very well say to a man, "Here, your income is under so and so, you do not have to pay anything; if it is over that you pay something in the order of about \$200 a year". There must be some method of grading, and I think the method of grading that the advisory committee has suggested, or some modification of it, gets rid of a great many of the anomalies that could exist if you went from no contribution right to full contribution without any graded amount in between.

Mr. MAYBANK: At \$900 you do not pay anything and at \$901 you would be in the paying class and therefore liable to pay the whole amount?

Mr. ANDERSON: Yes.

Mr. MAYBANK: That is the type of anomaly to which you were referring?

Mr. ANDERSON: Yes, and it could be worse as you get to the point where you add other social insurance measures.

Mr. JOHNSTON: You could start at \$1 and have a graduated scale from there up, but as a matter of principle I am inclined to think the principle involved in the income tax is about the fairest type of contribution or tax that can be arrived at. I am more inclined to favour that method than anything else because I think it is the fairest type of tax we have come to yet.

The CHAIRMAN: Any other questions?

Mr. ADAMSON: Does not Sir William Beveridge envisage equal payment for all citizens of the state for minimum benefits? I do not see anything wrong

with an equal payment for all citizens of the state. After all, even if the insured person paid the whole cost of the insurance it would come to about six cents a day. We do not assume under this scheme that the assured person will pay all the cost of the insurance. We assume he will pay less than half, or approximately the cost of a daily newspaper. Surely there are very few people in this dominion to-day who would not be perfectly willing and glad to make such a contribution if they are going to be included under such a scheme as this.

Mr. MACINNIS: Mr. Chairman, Mr. Adamson made a remark that I think we cannot accept in connection with this Act, or as I see the Act. He said, "an insured person." That means one person is insured and another person is not insured. My understanding of the Act is that everybody is insured. Consequently we cannot refer to insured persons and uninsured persons. All are insured under the Act. I think Sir William Beveridge put himself on record very clearly as being opposed to any sort of means' test. I have not got time to go into the means' test now but it is obnoxious for many reasons. We were told before the war began the reason people were unemployed was that they would not work but it was clear that when work became available there were only a very few who would not work. The same thing applies to people who will not pay under a scheme of this kind. The principle underlying the Insurance Act is that it is in the interest of the nation to have healthy people. Consequently the nation must pay for attaining that through the total pool of production, and whether a man pays taxes or not if he is engaged in producing wealth he pays his share of the Unemployment Insurance Act. Whether he gets that wealth or whether he does not is not material as far as the Act is concerned. It may be very material as far as the individual is concerned, but everyone who produces wealth, who works, adds to the total pool of wealth out of which all these services must be paid, and consequently is a contributor under the Act.

The CHAIRMAN: Any other questions?

Mr. ADAMSON: I made my point because I know how advantageous it is to get away from any means' test, and how bad a thing a means' test is in any form at all. That is why I raised my question.

Mr. MAYBANK: Has there been any actuarial attention given—of course, it would have to be speculative to a considerable extent but it may, nevertheless, have been considered—to the savings by a means' test, the difference between the payments if we had no means' test and the amount paid out if we had a means' test? Has there been any collection of data?

Mr. SMITH: Not by us.

Mr. MAYBANK: Not by the insurance people. Mr. Chairman, do you know whether there is any calculation of that sort?

The CHAIRMAN: I am not aware of any, Mr. Maybank.

Mr. MAYBANK: Am I right that our material indicates that the Beveridge plan is the only one at the moment before the world which proposes no means' test. We have quite a bit of data on our tables. I know New Zealand has a means' test in everything, but have we any other example to which we can go besides the Beveridge plan? I have the New Zealand plan pretty completely, and I think it will be found that even in that the benefits are only paid provided the income is less than a certain amount. However, I speak subject to correction.

The CHAIRMAN: Any other questions?

Mr. MAYBANK: You have not any data on that?

The CHAIRMAN: Not at the moment; I think we will have some information before we begin to discuss the bill. On your behalf I express our thanks to the members of the Canadian Life Insurance Officers Association for their presence here, their cooperation and their presentation. Thank you very much. We will adjourn until Thursday.

Mr. MACINNIS: Before we adjourn, Mr. Chairman, may I ask if we are getting near the end of these submissions?

The CHAIRMAN: Yes, we are.

Mr. MACINNIS: So that we can get down to discussing the Act.

Mr. LALONDE: May I draw your attention to this point? I have received from my people a request for a French version of the Marsh report. I think that has not been printed yet, but if it can be done as soon as possible—

The CHAIRMAN: Yes, we are endeavouring to hasten the publication. There has been some difficulty with the printing.

Mr. SMITH: May I say thank you, gentlemen, for the very kindly and courteous hearing you gave us and also say how sorry we are that we did not have copies of this brief in your hands some few days ago even in mimeographed if not in printed form, but unfortunately we did not get time to do that.

The committee adjourned at 12.30 p.m. o'clock to meet again on Thursday, June 10, 1943, at 11 o'clock a.m.

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Parliamentary Social Security, 1943
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(SESSION 1943
HOUSE OF COMMONS

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(SPECIAL COMMITTEE

ON

(SOCIAL SECURITY)

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 19

THURSDAY, JUNE 10, 1943

WITNESSES:

- Mr. H. H. Hannam, President, Canadian Federation of Agriculture;
- Mr. R. Martin, Secretary, Co-operative Federee de Quebec;
- Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health;
- Mr. A. B. Farmer, President, Medical Liberty League; and
- Mr. Alexander B. Davies, Medical Liberty League.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

THURSDAY, June 10, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m.

As the Hon. Cyrus Macmillan, the Chairman, was absent Mr. J. A. Blanchette, the Vice-Chairman, presided.

The following members were present:—Messrs. Adamson, Blanchette, Bourget, Bruce, Casselman (*Mrs.*) (*Edmonton East*), Cleaver, Côté, Donnelly, Fulford, Gershaw, Gregory, Hatfield, Howden, Johnston, Leclerc, Lockhart, MacInnis, MacKinnon (*Kootenay East*), McCann, McGarry, Shaw, Warren and Wright.—23.

The Vice-Chairman introduced the following members of the Canadian Federation of Agriculture:—

Mr. H. H. Hannam, President;

Hon. George Hoadley, Health Study Bureau;

Mr. Ken. Betzner, Vice-President Ontario Federation of Agriculture;

Mr. R. Martin, Secretary, Co-operative Federee de Quebec.

Mr. H. H. Hannam was called, presented a brief, was examined by the Committee and retired.

Mr. R. Martin was called. He briefly addressed the Committee, and retired.

Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, was recalled and examined.

Mr. A. B. Farmer, President, Medical Liberty League, was called, presented a brief, was examined and retired.

Dr. Heagerty was further examined.

Mr. Alexander B. Davies, Medical Liberty League, asked, and was given permission to address the Committee. He made a brief statement and retired.

The Committee adjourned at 1.45 p.m. to meet again Friday, June 11, at 11.00 o'clock, a.m.

J. P. DOYLE

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS, June 10, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Deputy Chairman, Mr. J. A. Blanchette, presided.

The DEPUTY CHAIRMAN: We have with us this morning The Canadian Federation of Agriculture officials, in the persons of Mr. H. H. Hannam who is president of The Canadian Federation of Agriculture, Mr. George Hoadley from the Health Study Bureau, Mr. Ken Betzner, vice-president of the Ontario Federation of Agriculture and Mr. H. C. Bois—I do not know whether or not he is here.

Mr. HANNAM: Mr. Martin is here.

The DEPUTY CHAIRMAN: Mr. Martin is replacing Mr. Bois from the Cooperative Federee de Quebec.

The brief is to be presented by Mr. Hannam. It gives me great pleasure to introduce him to the committee.

Mr. H. H. HANNAM, President, The Canadian Federation of Agriculture, Called.

The WITNESS: Mr. Chairman and members of the committee, may I take a minute to explain our federation of agriculture, and to list the organizations that are represented.

The Canadian Federation of Agriculture is a national federation of farm organizations from all nine provinces and represents all branches of agriculture. Included in it are:—

The British Columbia Federation of Agriculture
Alberta Federation of Agriculture
Saskatchewan Cooperative Conference
Manitoba Federation of Agriculture
Ontario Federation of Agriculture

The following organizations in Quebec:—

Cooperative Federee de Quebec
L'Union Catholique des Cultivateurs de la Province de Quebec, and
Quebec Council of Farm Forums
Maritime Federation of Agriculture
Prince Edward Island Federation of Agriculture

The provincial units of the federation mentioned above include in their membership large cooperative organizations, such as:—

Manitoba Pool Elevators Limited
Saskatchewan Wheat Pool
Alberta Wheat Pool
British Columbia Fruit Growers' Association
Fraser Valley Milk Producers Limited
United Farmers Cooperative Co. Limited
Canadian Livestock Cooperative (Maritimes)
Nova Scotia Fruit Growers' Association

There are three inter-provincial organizations that are not divided into provincial units:—

The Dairy Farmers of Canada, which is a national organization of the dairy industry;

Canadian Horticultural Council, which is a national organization for fruit and vegetable producers;

United Grain Growers Limited, operating in the three prairie provinces.

May we point out at the start that farm people have been studying not only their own rural health situation but also the national situation as a whole, and the responsibility of the individual in that picture. This is important for us to remember when we consider the contents of the pamphlet, "Health on the March"—that it was compiled, not as material to superimpose on the people but as a result of the thinking of the people themselves. The farmer realizes that he is a part of the whole social economy, and he does not hesitate to speak for all Canadians.

As the members of this committee have had the opportunity of studying the principles of the Canadian Federation of Agriculture in regard to national health planning, and no doubt have copies before them at the present moment, we will not go into the details; but will endeavour to give the broad picture presented by these principles in their relationship to the draft bill which the members of this committee are considering, and deal later with any questions arising from this.

A brief summary of our plan for national health insurance which we have tried to give in a few sentences, is as follows:—

To be successful, a health insurance plan for Canada must be national in scope.

All health services under the plan must be available to all citizens resident in Canada.

The cost of the plan shall be defrayed from the federal treasury in order that all citizens will contribute equitably according to their ability to pay.

The promotion of positive health and the prevention of disease is the primary purpose of the plan.

We recommend direction of the policies of the plan by a central independent commission at Ottawa; and each province, while preserving full provincial autonomy, shall, through legislation, create a provincial health insurance commission for administration of the plan in each province.

We believe it essential to work out a proper distribution of all health personnel, hospitals and other services through regional planning.

We believe that the place of the general practitioner should be recognized as vital to the success of the plan; and that health centres in rural and urban districts be established from which his work shall radiate.

We emphasize that the active participation of all members of the community shall be the driving force which shall assure the full success of the programme.

We urge the importance of the dominion government enacting legislation to put this plan into effect at the earliest possible date; because it will be recognized that some time will elapse before provincial action can be undertaken.

That is the summary of the plan.

The need for a collective attack on Canada's health problem is clearly shown by the evidence brought forward by the various provinces, in their

submissions to the Rowell-Sirois Commission. There are a number of sentences here which I wish to repeat because I think they are very well condensed. In brief, here is the picture:—

Cost of medical services are increasing, but the ability of their people to pay is *not* increasing.

The high incidence of preventable disease and death.

Inadequacies of hospital facilities, especially in rural areas.

Inadequate accommodation in mental hospitals.

The expenditures on behalf of the mentally diseased and mentally defective have increased more rapidly than the general population rate.

The problems of cancer, mental illness, venereal diseases and tuberculosis, which ignore provincial boundaries, can best be attacked by unity rather than by nine more or less sporadic provincial attacks.

Early diagnostic and preventive measures are needed all down the line.

The urgent need for properly organized services in the field of maternal and child health.

The increase in the costs of dependency because of illness and premature death.

The crying need for federal responsibility and financial aid—in fact, some system of national health insurance—if the problem is to be solved.

They acknowledge their provincial lacks, but state that they are unable to finance the health services they should be giving to their people.

That is the end of the quotation from the report.

We endorse whole-heartedly the views expressed by the Minister of Health, Honourable Ian Mackenzie, when he stated:—

There is a strong public feeling that, to be successful, health insurance should be on a national basis.

and again:

The fourth principle recognized by the committee is that public opinion favours a health insurance programme that shall be nation-wide in its scope and operations.

As we have pointed out in our principles, the war has increased the demand of the people for a national plan because they are seeing the great heights their war effort can achieve when the force of the people is released to surmount provincial boundaries. Similarly, the whole set-up of the National Health Bill must be such as to attract and hasten full co-operation of all Canadian provinces. The synchronization of provincial action is imperative if we are to face the future with a concerted national attack on our health problem.

The federal government must give leadership in this; and the first step is to envisage the Canadian problem as a whole, from the standpoint of national needs. This survey should set forth the proper distribution of all health workers, hospitals and services needed to protect the country as a whole; so that, regardless of provincial boundaries, all Canadians shall be on a basis of equity so far as the services are concerned. This must be done before we embark on health insurance. The wisdom of this cannot be questioned. To set forth public health standards only is not enough; the distribution of medical care must be assured by the mapping out of health centres, with the proper integration of one with the other. With this picture before them, the provinces will begin to see themselves as units of a complete whole, with

the isolation of the past eliminated. To say—"We will pass a national bill" is not enough; a plan must be presented to the provinces, and then they must set to work to carry it out themselves.

Following the announcement across the country of a national health bill, we were disappointed to note that the advisory committee destroyed this concept of a national plan in these words:—

That the constitution—

Presumably the Canadian constitution.

—as at present understood and interpreted, prevents the dominion parliament from adopting a single comprehensive national health insurance act. (Book 1, page 17)

We cannot agree with this, because there is nothing to prevent each province voluntarily passing legislation and setting up its own independent administrative commission, which shall cooperate with the central administrative health insurance body. We visualize a perfect preservation of autonomy—nine independent units, with the central commission as the "clearing house", the body which shall insure the balance of the whole, to direct and coordinate, to keep all units up to an equally high standard. The rapid development of our northern areas, with the opening of the Alaska highway, must also be prepared for.

Financing the Plan.

The people know that the plan must be paid for. Their interest is that it shall be paid for in the most direct and economical manner possible, on a basis of equity for all, and with the least disturbance of their personal lives. We fully recognize the weakness, bottlenecks, and difficulties which would have to be faced under a contributory system. It would be impossible to anticipate the endless problems of adjustment, cost of collections and boards of administration and appeal required all over the country. Moreover, we would create a heavy cost of overhead to be borne by the plan. Already, on paper, the draft bill has shown us what we would have to face. The method of raising the necessary funds is so complicated, so involved, that we doubt whether any member of this committee could return to his constituents and make them comprehend it. It has been emphasized by many bodies that there should be no financial barrier between the people and the services; yet in this draft bill we find endless barriers imposed.

From page 32-41 in the 558-page report of the Advisory Committee on Health Insurance, we see the following headings: Determination of Questions; Investigations of Complaints and Disputes; Appeals; Inspection; Offences; Legal Proceedings, etc. The Details of Assessment Return must show (A) live stock; implements, tools and equipment; ships, boats, nets, etc., household furniture; library; mortgages, bonds, stock and other investments; cash on hand and on deposit; amounts receivable, surrender values of insurance policies, and all other personal property together with a statement of amounts owing. (B) There is to be given under this head for each parcel of real property: 1. the municipality in which it is situated. 2. the description of the parcel in the last assessment notice for taxation. 3. the assessed value in that notice. 4. the amount of any mortgage, charge or loan and the holder thereof. (C) There is to be given under this head the amounts received as salary and wages, bonuses and gratuities; pensions, annuities, professional fees; director's fees; value of board, living, house or subsistence allowances; and all other earnings or income or receipts of the year.

We contend that however carefully the different levels are set, there is bound to be lack of equity at some point and a great problem entailed in discovering at what level no contribution is possible—especially amongst the hundreds of thousands of assessed contributors. This includes the great majority

of farmers with unpredictable incomes and varying expenses. Is Canada's Plan for Health to be a "release" for the people, or a punitive measure? Surely those who drafted it could not have realized the almost impossible position in which they would be placing a large number of citizens. On the other hand, some have commented that perhaps it is supposed to be a method of solving unemployment, by providing salaries for thousands of civil servants engaged in assessing, investigating, etc.

General taxation is recognized as securing a contribution from each individual as nearly as possible in direct proportion to his ability to pay. We need the money to finance Canada's health plan. Instead of employing devious methods to secure it, the most logical, direct and economical method is that which we advise—to use the national consolidated revenue fund. There is, in reality, but one source from which revenues are drawn—the people's pockets; and realizing this, it is the part of wisdom to use the method which our nation has developed over a long period of years and considers equitable and effective.

Some may say that people will not appreciate what they are receiving unless they make visible monetary contributions. Well, take public health which we all recognize, in spite of inadequate budgets, has done more to promote health and lower our death rates for preventable diseases than any other one factor. Take all these services which protect our communities. Do people hand over individual contributions? No. It is done "en masse" through taxation. What about the 36 per cent of wage-earners in Canada (according to the 1941 census) whose earnings are below \$10 a week and farmers who fall in this category? Should they be asked to make any direct contribution or any substantial contribution? And shall we say that they must be made to feel like paupers? We do not. Moreover, there will never again be any doubt in the people's minds as to where the money comes from for all government activities. The war has dissipated the last illusion; call it "the public purse" but the people well know that there is only one source—"their private pockets".

Hon. Mr. Mackenzie, in reading the draft bill to this committee (book 1, pages 28-29) explained the question of financing in these words:—

Whatever formula may be adopted as between dominion and provinces, it will be of interest to note that contributions from employees, employers and assessed contributors are to provide 48·7 per cent of the overall, leaving 51·3 per cent to be made up by the dominion and the provinces from the public treasury.

This means that the draft bill proposes to pay approximately half of the cost of the plan from the treasuries of the dominion and the provinces. In other words, the people would pay half the cost through the ordinary channels of taxation. Why not all? Our plan simply proposes that the people shall pay, not half, but the whole of the cost of the treasury method.

We are entirely opposed to the placing of any ceiling above which a proportion of the Canadian people would be excluded from the plan. We endorse the second principle put forward by the advisory committee that:—

A real health programme can be effective only if it embraces the entire population.

And also we endorse the statement of Hon. Mr. Mackenzie when he said:—

Since our fundamental purpose is the improvement of the health of the people we feel that this proposed legislation must apply to everybody. . . . The health of Canada is, therefore, one single problem, and we cannot break it up into geographical segments.

But we are disturbed by another statement made by the minister. It is this:—

The provincial scheme contemplated in the committee's recommendations is broad enough to cover the entire population—employed and unemployed, master and servant, farmer and industrialist, the working adult, the aged, the indigent and the children. Nobody need be excluded. Nevertheless the way is left open for a province to limit benefits to those having less than a certain income ceiling.

We consider that that last sentence neutralizes the effect of the first statement.

In our opinion it is regrettable that the draft bill infers that there might be different ceilings of income in different provinces. We note that the Canadian Medical Association in their principle 8 says:—

That the plan be compulsory for persons having an annual income below a level which proves to be insufficient to meet the costs of adequate medical care.

That is a definite recommendation for a ceiling and for a plan to apply only to the people in the low income class.

This is inconsistent with the full operation of preventive medicine. There has been much evidence placed before this committee during the past two months in regard to three problems which Canada faces—namely, prevention and control of tuberculosis, mental illness and venereal disease. These problems disregard provincial boundaries, income levels or social status. If we are to face these health problems and many others with realism, all Canadians must have equal service and protection. In short, we are emphatically opposed to the fixing of any ceiling to divide Canadian citizens into two camps—one inside and the other outside—in respect to a national health plan; but we consider it would be still worse to permit different ceilings in different provinces.

Instead of one ceiling dividing the Canadian people into two parts you might have nine different ceilings in nine different provinces, and that would just neutralize the simplicity and the effect of the plan.

One of the strongest reasons for the inclusion of all citizens in the plan is that it is impossible for us to evade our responsibility in tackling Canada's population problem, which has been disregarded in the past with disastrous consequences to our national life. On pages 10-11 of "Health on the March" we stress this problem, and show where it should be attacked.

We note on pages 183, -192-196 in the health insurance report of the advisory committee "that the ageing of the population of Canada is a problem of major importance, particularly in view of the present conflict when so many men in the very flower of youth, are answering their country's call for sacrifice." ... "This ageing of the population is a serious problem both from an economic and social standpoint. With a continuation of the decrease in the rate of natural increase and the lack of any heavy immigration, the proportion of infants and persons in the younger age brackets, is becoming less, and consequently the population of Canada is ageing more rapidly. If Canada is to survive as a nation, something must be done about the re-stocking of the human elements in the population. . . It is doubtful whether Europe, after the present conflict, will be able to supply any appreciable help in this direction for a number of years, her own stocks being so badly depleted. Therefore, we must look for our own corrective factors—

1. An increase in natural reproduction.
2. The prevention of disease.
3. The prolongation of life; and

4. An improvement in the physical and mental efficiency of the Canadian people. Salvage of a considerable amount of the present wastage of human resources of the country is possible by—

1. Eliminating preventable deaths.
2. Reducing deaths in the early ages to a minimum; and
3. Eliminating the dangers of motherhood, childbirth and early infancy."

These last we would particularly stress. Dr. Couture warns us (Canadian Home Journal, March 1943—Article, "Canada's Greatest Asset, her Mothers and Babies.") that "since the outbreak of this War, Canada has suffered the loss of 71,000 infants, including stillborn babies." Surely this appalling wastage is an uncontrolled policy amounting to race suicide. Our health plan we contend would cut down this wastage at the source; eliminate the costs of having children and insure that quality is developed along with quantity. For selected groups of the population? No, for all Canadians.

We are concerned about the poor prospects which the draft bill holds out in our opinion for farm people. In his presentation, Dr. Heagerty said:—

You have large cities with very large industrial areas but you have large rural areas, and treatment afforded people in the urban areas is bound to be quite different to that of the rural areas. In the cities you have all facilities available. You can give all the benefits that are laid down and do so immediately without any disruption of existing services, but when you go into rural areas then you have got to do something else... You have got to provide them with whatever is available until the time comes that you will be able to give them the entire service.

It has been said on a number of occasions before this committee that rural people will have to wait some time before they get a service equal to that of urban centres. That is the position farm people have had to accept in the past. They have a right to expect equal consideration under a national health plan.

On May 14th before this committee, Dr. Couture made a vigorous plea on behalf of the women and children of Canada; and much evidence was brought forward to show the deplorable state of affairs in rural areas. He said that:—

38 per cent of all births, that is 96,634 babies, were born in 1941 to mothers living in the country.

In "Health on the March" we quoted Dr. Couture saying:—

Some 20,000 mothers in Canada each year have no medical attention at the birth of their children...and only one quarter of all births have pre-natal care.

We agree with Dr. Couture when he said:—"In Canada, then, the question of maternal care in the rural sections deserves first place in any health scheme."

Mr. CLEAVER: Would you mind an interruption here? Have you the breakdown of the 20,000 cases where there was not a doctor in attendance at the births showing how many of those are urban births and how many are rural births?

The WITNESS: I haven't got it here; we can get it from Dr. Couture.

Dr. HEAGERTY: It is in the report of the advisory committee.

The WITNESS: Here are some figures which show the discrimination against rural areas in the distribution of health personnel (from study of the distribution of medical care and public health services in Canada). They are

for 1931, and since then, the War has aggravated the situation. In Canada the ratio of doctors varied from 1 for 872 people in one province to 1 for 1,578 people in another province; dentists, 1 for 1,879 people in one province, to 1 for 4,134 in another province; nurses, 1 for 351 people in one province, to 1 for 859 in another province. In the 20 cities of 30,000 or over, there was 28 per cent of the population of Canada. But this 28 per cent was served by 45 per cent of the doctors, 48 per cent of the nurses, and 49 per cent of the dentists.

At present over 40 per cent of the population of Quebec live in rural areas, but only 13 per cent of the doctors are there to serve them. Similar conditions prevail in other provinces. We would ask every member of the house, particularly those who represent rural people, if they wish to allow Canada's health bill to perpetuate these conditions. We, who are here to-day on behalf of the people who live on the land, emphatically protest against any inequality of service being offered to farm people.

In the next few pages I am going to give you the views of farm people expressed through radio forums from farms across Canada. In no case is this opinion of one person; each of these is the opinion of a group that wrote out a report following the discussion of a national health scheme.

British Columbia—Heffley Creek.—“The doctors won't come out if a patient can be moved at all. If they do come they charge about \$60 for a thirty-mile trip one way. There are no health activities of any sort in our community.”

Alberta—Foisy.—“Just one doctor in this area—about 500 square miles, and you may see him and you may not. If one does see him, one waits several hours to a day.”

Irma.—“We are very inadequately served. Maternity cases have to travel twenty-five miles and over to reach hospital or doctor.”

Legent.—“We have no doctor from Lethbridge to the Saskatchewan boundary and from Bow Island to the Montana boundary.”

Mallaig.—“Present doctor covers about 2,000 square miles.”

Saskatchewan—Algrove.—“Nearest doctor serving approximately 700 square miles.”

Grenfell.—“Our local doctor serves about 800 square miles... He is undergoing medical treatment so this territory will be without a doctor for the next three months.”

Leader.—“Health conditions in this community are terrible. Our school is never visited by either doctor or nurse. This fall one family had a child with contagious disease... finally the school was closed up, as teacher and all pupils were sick. Mothers here, who never have a doctor at the birth of a child, least of all pre-natal care, most of them are wrecks and old long before their time. It's a shame and a disgrace for a Christian, democratic country such as ours to allow these conditions to prevail.”

Manitoba—Durban.—“Over 4,000 square miles and over 6,000 people served by three tired old men 65 and over 70.”

Foxwarren.—“Health is neglected. The district is greatly lacking in doctors and dentists. People go from forty to eighty miles to see a dentist.”

Ontario—Paisley.—“The doctors in nearby towns have been depleted 50%—in case of epidemics they would be swamped.”

Melanethon.—“Doctors are scarce and their charges too high. A case of emergency is never neglected. On the other hand, nobody goes until they have to.”

Essex.—“There are not nearly enough doctors to take care of the actual calls, let alone do any preventive work.”

Campbellcroft.—“Our local doctor is 82 years of age and not practising.”

Chatsworth.—“Our present practitioner is obliged to cover an area of over 300 square miles. In case of an epidemic he could not begin to serve this community adequately.”

Holstein.—“Very poorly served. The only medical services available in the township are one afternoon a week when the doctor from Ayton is here for a few hours. And people around here do not always arrange to die that afternoon.”

Meaford.—“There is neither doctor nor dentist in this township. Doctors will not come out to the country unless the patient cannot be brought to the hospital.”

Seaforth.—“The government sponsors the TB testing of cattle, pays for loss and has blood testing every year free of charge. What about humans? Let's take our hats off to Russia so far as health is concerned.”

Walton.—“Almost all the older people have poor health. At least 60 per cent of the young men did not pass army medical. Number of doctors has been cut by 50 per cent. It is impossible to obtain registered nurse. We can't pay enough to compete with the opportunities in the city.”

Almonte.—“Our doctors are all aged now... so busy on curative work that we have little or no preventive work.”

Wilton Grove.—“Before the war there were sufficient doctors; but because of enlistments it is now very difficult to secure a doctor; for though we are close to London, many doctors in the city refuse to come out to the country.”

Burgessville.—“City doctors eight and ten miles away do not want to come out to the community unless you are a regular patient with a certain doctor. Present private practice forbids preventive medicine.”

Mount Elgin.—“We have lost both our doctors in our township and it costs much more to get a doctor from town.”

Norwich.—“One farmer faces a debt of \$1,300 for medical services.”

Peterboro.—“Most doctors absolutely refuse to go to country calls, regardless of pay.”

Picton.—“The medical men of our county are too few to give adequate service to all communities, being kept busy principally with their town practice.”

Finch.—“At present we have no medical service. Our local doctor being in military service.”

Belwood.—“No doctor in the township which makes it too expensive for average income as the doctor has a long distance to come.”

Kenilworth.—“The doctors are scarce and a great number of people are not in a position to pay; so they do not call a doctor unless they are seriously sick.”

Quebec—Foster.—“We have a health unit but territory is too great for adequate results.”

Farnham.—“Health unit is not adequate. Child care only, good as far as it goes, but we need something more concrete than just advice.”

Sawyerville.—“We haven't a doctor here, but we have two undertakers—we can die any time.”

Bury.—“Private practice adequate only in case of extreme necessity owing to distance and inability to pay fees.”

Lennoxville.—“Those who have the money to pay can get service and the very poor are given attention in emergencies. We all have a dread of hospitals and doctors because it has taken many of us several years to pay for one or two operations or long illnesses.”

Way's Mills.—"It depends on your luck whether you must have more medical care than your finances will stand. Should have the doctor oftener, but can't afford it."

Ayers Cliff.—"We're waging a war for equality of rights for all people. Give all proper equal opportunity for good health as an essential for good citizenship."

New Brunswick—Centreville.—"There are five parishes on the west side of the St. John river in the county of Carleton without a medical practitioner of any kind."

Debec.—"There is no community doctor and it is almost impossible to get one from the nearest town ten miles distant."

Woodstock.—"Very uncertain getting a doctor when needed. Doctors seem indifferent to rural communities."

Moore's Mills.—"No medical or hospital facilities, nor even a registered nurse."

Bloomfield Station.—"The war has taken away what we had—one doctor is doing the work of three."

Summerhill.—"The health of the community is far below the standard that it should be if we had proper medical care. We have no public health services at all."

Welsford.—"Before the war we had a local doctor and a drug store. Now we have neither."

Cooksville.—"A tubercular family and many children needing dental care and tonsil operations."

Young's Cove.—"Present practice of medicine serves us poorly and is very expensive. Too much per mile—too much ground to cover."

Petitcodiac.—"With so many doctors joining up in rural areas, and what are left having to cover such great distances, it's getting serious."

Nova Scotia—Amherst.—"No doctor nearer than 15 miles and town doctors not willing to come out into the country in winter. Cost from \$15 to \$35 per call. A man shot in the hip at 1 o'clock p.m. one day was until 9 o'clock p.m. without a doctor; and until 7 o'clock the next night before he could be in a hospital."

Elderbank.—"Our doctor has 275 miles of highway to travel. Many do not consult him because of cost of services. Immediate federal action needed."

By Mrs. Casselman:

Q. Have you any reports that were favourable—reports that you did not quote from?—A. Yes, some were favourable.

Q. Have you any figures showing the proportion of the replies received which were favourable and those which were unfavourable?—A. With present medical services?

Q. In your coverage at this time?—A. I would have to speak from memory or make an estimate. I would think that 10 or 15 per cent of the reports were favourable.

By Mr. Howden:

Q. Would you say that that is a pretty general picture in the country?—A. I would not say that picture is accurate for the whole country. We certainly have gone through the reports and picked out these reports, but this is a pretty general picture. This is too accurately a majority picture to be able to say—

By Mr. Donnelly:

Q. What proportion of those reports that you have there show that the cause is that the doctors have enlisted?—A. I think the number that I have listed here may be very fair. We have not analyzed them on that basis. Again I would say that the minority are due to that cause.

By Mr. Donnelly:

Q. A great many of those that you read out were due to the doctor enlisting?—A. That is true.

Q. The doctor shortage?—A. Yes; as near as I would venture an answer, the minority are for that purpose.

By Mrs. Casselman:

Q. Is it not true that about 30 per cent of the doctors and dentists are now in uniform and away from the civilian population?—A. I doubt if it is as high as that.

Mr. DONNELLY: Thirty per cent of the doctors have gone from the constituency I represent.

By Mr. Howden:

Q. Let us put it this way: Before the war broke out at all were these people properly served?—A. That is the point. I think we can all agree on that, that before the war broke out at all these districts that we are talking about were not adequately served with medical services in the great majority. That applies to the great majority of rural communities across Canada and that is the point I should like to make.

By Mr. Shaw:

Q. Have you any idea as to the number of doctors serving the rural areas who have moved into the cities and towns because of the doctors who have enlisted from these points? I feel that has aggravated the situation in the rural areas very considerably.—A. Yes; that is part and parcel of the same thing. You see, it means that while actually the doctor did not go from the rural community into the army, the doctor went from the city practice into the army, and the rural doctor moved in there because he could better himself.

Mr. JOHNSTON: In the final analysis the doctors are not serving the rural areas as efficiently as they should be served, no matter for what reason. That condition was the same before the war as it is now, although it may be aggravated now. That condition existed before the war.

The WITNESS: Yes, and was getting worse before the war broke out and leading up to the war; there is no doubt that the war has very seriously aggravated it.

By Mr. McGarry:

Q. Is it not a fact that it is very difficult to induce younger graduates to go into the country practice now?—A. Yes.

Q. I find down in my province that young men are loath to go into a country practice because they have not got the facilities for hospitalization and so forth that you find in towns and cities, so that really the medical man serving a rural section has reverted back to very little more than a consignor of cases to a hospital, and so for that reason a great deal of the work that he did years ago before the facilities of hospitalization were offered to his patients has become lost to him.

If I find a case of pneumonia or typhoid or any of these things, I certainly will consign them to a hospital. If I get a case that requires surgical work—well, before we had hospitals near at hand I used to do some of that at home—I simply consign that case to some surgeon who attends the hospital, and the medical doctors in the country get little or nothing for that service, but possibly he has performed the most important work, that is the diagnosis. Therefore to-day the tendency is towards sending patients to the hospital. I do not know what inducement can be given to young men to enter into country practices.

Mr. HOWDEN: Give them a living. They did not get a living in the past. They could not go to the country because they could not live.

The WITNESS: I think I would go this far and say I doubt whether we can ever again make conditions that provide a practice attractive enough in rural districts to attract young doctors there to do the job.

By Mr. Fulford:

Q. What is your concrete proposal to overcome that? Would you regiment the doctors? If you go that far I am afraid you would have a big falling off in the number of entries to the medical schools.

Mr. HOWDEN: Give them an opportunity to make a living.

Mr. FULFORD: I know a case of a rural doctor who recently died. He had a splendid practice. He had access to no less than three hospitals. His widow has advertised in the larger dailies of Toronto and eastern Ontario, but she cannot get a single doctor to take his practice. You mentioned the fact that the trend of the rural doctor is to the city. Is not that a general trend throughout the country? I am going to ask you this question: Do you think that this trend of farmers and farmers' sons moving from the country district into the city could be somewhat stopped if there were adequate medical facilities in the rural district? After all the old complaint of the farmer that he was isolated no longer exists because he has his radio, his motor car and his means of transportation and all kinds of entertainment, the telephone and so on, and yet the trend is still going on. Do you think one of the pertinent reasons for that is his fear of ill health or not being able to get proper medical attention?

The WITNESS: It is partly that. As far as I can see the answer to the question of medical services in rural districts depends upon a complete national health plan, and I do think that under that you can make a provision that the services there are attractive enough to get not only young doctors, but the most socially-minded and the finest of them into that kind of work.

By Mr. Donnelly:

Q. I might say in that respect I come from a part of Saskatchewan that has municipal doctors all hired by the municipalities. Some difficulty has been experienced even there with regard to young doctors.—A. Might I suggest that I have just three pages left?

The DEPUTY CHAIRMAN: Yes; I think we should allow Mr. Hannam to finish his brief and have the questions after.

The WITNESS: May I suggest you will find partial answers to the questions we have been discussing in the part of the brief that remains?

We believe that the general practitioner is the keystone of the arch of the whole plan; and to give him an opportunity to do his best work, we recommend that health centres be established in both rural and urban districts. The mapping out of the country to which we have already referred, will show the logical location for these. They need not be elaborate but perhaps similar to the municipal and union hospitals in the west. All necessary services such as X-ray, laboratory, dental, nursing and specialist should be coordinated in these

centres. The present method, especially in rural areas, of doctors struggling individually against the problem of ill-health, would be supplanted through these health centres by doctors working together, with the advantages of cooperative use of equipment, and the opportunity of consultation with each other in their work.

There is one thought which is very close to the hearts of the people; and that is the question of those who will come back after the war. In meetings and forums they have expressed themselves in no uncertain terms that their men must be part of the community so far as their health service is concerned; and not have to travel many miles and prove their right to services before medical boards. They remember their experience after the last war. Will we be ready for this, when men return to their own communities all over Canada? Will we be ready for the doctors and others who have served well in the forces, and who have never had a practice? They want to go on serving humanity, and they would have an opportunity in doing so under our plan.

In regard to presentation on health insurance commissions—it has been stated before this committee that the Federation of Agriculture “wants agriculture to have the major part in administration”. Also that “agriculture wants to place the medical, dental and other professions in a subsidiary position.” That is quite wrong. The Federation of Agriculture has no wish to have and has not at any time asked to have, the majority of control; nor have we asked for the professions to be placed in a subservient position. We did say that the health insurance commission should be composed of representatives of those giving and those receiving the services, with the majority of representation to be lay people; and we have not asked for the majority of these to be farm people. We agree with the Trades and Labour Congress when they said:—

We need to be assured that the primary purpose of the Health Insurance Act is to operate for the benefit of the contributors and not in the interests of the medical profession... We are naturally prepared to concede to the medical profession the right to representation, but we could not possibly agree to them having entire control.

Our position is that we ask for equitable representation by all groups concerned, and we are clearly opposed to a monopoly by any one group. We do not want a monopoly by our own group.

The people are becoming more and more alive to the meaning of preventive medicine, and are educating themselves to accept it in its fullness. The general practice of medicine must be enabled to do as much and more than public health has done in the past; and this can only be accomplished by a fully integrated programme. We must make it to the advantage of all health workers to practise preventive medicine in their daily work; and for the people to cooperate to the full. The health centres should be utilized for educational purposes, as we have outlined in the pamphlet, “Health on the March” which is before you. And this should include local statistics. Nobody knows better than the Federation of Agriculture the demand for figures concerning their own community situation; and there is an absolute dearth of these in rural areas. Our thoughts, our efforts, our money have been so concentrated on sickness in the past, that it is difficult for us to reverse the procedure, and concentrate on positive health. But it can be done, if the plan is so organized; and our health workers and the people cooperate to the full. In this field of educational endeavour, the Canadian Federation of Agriculture has given much thought and study in the past few years; and it is prepared to cooperate to the fullest extent with all others in this field in the important work of preparing the people for this vital step in Canada’s social development.

Summary

These are the broad principles for a national health insurance plan for all the people.

It would give us all the advantages of constructive national leadership without having to revise the B.N.A. Act and without encroaching upon provincial autonomy.

It is agriculture's proposal envisioning "good health for everybody" and setting forth a workable plan to achieve it. The whole motivating power of this dominion-wide plan encourages everybody to think in terms of keeping well. Under it, all the people would participate; all would contribute according to their ability to pay. Under it there would not be a single person of high or low estate who would be denied complete health services. Under it there would no longer be a charity bed in any hospital in the nation. That is one of the big things.

When that is done, it will be a great day for our dominion. That all may well be proud of the progress of our enlightened society.

The organization we represent places this plan before the government. It is not a plan for farm people alone; it is a plan put forward by farm people for all the people of our land.

Thank you very much.

By Mr. Howden:

Q. Before you retire I should like to ask you a question or two. First of all, are there copies of this submission for all the members of the committee?

Some Hon. MEMBERS: It will be printed.

By Mr. Howden:

Q. I would say from your submission that what you are advocating is really state medicine? Would you not agree with me?—A. Not exactly.

Q. You have a friendly interrogator. I may say I have been advocating state medicine in the House of Commons ever since 1930, but I have been pretty much a lone voice crying in the wilderness.—A. I would say a modification of state medicine because it would be handled by independent commissions.

Q. What I really rose to my feet to ask you about was this: there are certainly phases in connection with state medicine that I should like to mention. Once you establish a system of state medicine you have no check on the people calling on the medical man because they are under no obligation to shoulder any cost of any kind except through general taxation. Have you thought of that and have you any, shall I say, means of providing against that possibility? You understand what I mean.—A. Yes. I doubt whether that would be a serious obstacle in this plan. My opinion is that it has not been a factor that has interfered with the municipal doctor plan in the western provinces. Now, that is my opinion. I am referring now to people visiting the doctor's office because he is fairly convenient.

Q. May I say I was a municipal doctor a good many years ago and my experience as a municipal doctor was this: quite a few people come to consult the doctor who have nothing the matter with them in the least. They came because it cost them nothing.

Mr. DONNELLY: That has been the experience in some municipalities, I understand, in Saskatchewan. In order to stop that in some municipalities there has been a fee put on the first visit, a fee of a couple of dollars. In some municipalities on the first visit to the doctor a fee of \$2 must be paid. After that he does not collect anything. That fee is put on to prevent people coming in to consult the doctor about nothing at all.

Mr. JOHNSTON: May I say my experience with doctors shows that they can make it so disagreeable for you if you have nothing wrong with you that you will not call the second time if you are not sick.

The DEPUTY CHAIRMAN: I think we should hear from Mr. Martin before we go on with Mr. Hannam's questions.

Mr. CLEAVER: I think it might be wise to question Mr. Hannam now while these matters are fresh in our minds.

The DEPUTY CHAIRMAN: I understand Mr. Martin is to say only a few words. Mr. Martin is connected with the Cooperative Federee de Quebec.

Mr. R. MARTIN, Secretary, Cooperative Federee de Quebec, called.

The DEPUTY CHAIRMAN: It gives me pleasure to introduce to you Mr. Martin.

The WITNESS: Mr. Chairman and members of the committee, to save time I shall try to make my remarks in English.

As the Cooperative Federee de Quebec is a member of the Canadian Federation of Agriculture I think it is my duty to tell the committee that we support the national health insurance plan as proposed by the federation.

We have to recognize the excellent work done by the dominion and provincial public health services, by the medical associations and doctors as individuals; but it must be said, too, that the work done in the matter of public health is not in accordance with the people's needs; and that very little attention has been given to preventive medicine in the past. More than that, in rural areas there are not sufficient possibilities for giving the citizens the adequate medical care they require in their homes. In some places no doctor is available, and in some other places the doctor is too far or the hospital facilities are not available. In urban areas citizens have doctors and hospitalization possibilities at their doors but they cannot pay for the services, and that is another problem. Even if they had the money in the case of urban areas or the money and the hospital facilities for the care of rural areas it is not certain that they would use the services at their disposal because they have not been taught prevention or nutritional problems. Public health is not only a matter of money, of personnel and institutions. Public health is first an educational and nutritional and housing problem. Public health is also in direct line with the problems of the restoration of rural life and the building of a strong, happy and prosperous country. If all citizens, young and old, are in a healthy condition, they must be a real asset instead of being supported by others; that means by the whole country. So I think that the dominion will support the application's cost of a national plan by the ordinary means of taxation. Public health is just another public service urgently needed by the whole population.

Once more, I think Quebec will support such a plan, and I am quite sure it will be a great drive for the future of our Canada.

The DEPUTY CHAIRMAN: Thank you, Mr. Martin.

Mr. SHAW: Mr. Chairman, I have two questions which I should like to direct to Mr. Hannam. Before doing that, however, may I say that I think we recognize that the success or failure of such a scheme as this will depend largely upon the attitude of such bodies as organized agriculture. Mr. Hannam stated, or at least he left the inference in my mind, that he was not satisfied with some of the representations of certain organizations with respect to the administration of the scheme. He states that the majority of representatives should be lay people. Might I ask Mr. Hannam to elaborate on that, and to specifically give us his straight-from-the-shoulder opinion in respect to the attitude of the Canadian Medical Association as far as administration is concerned. That would be my first question.

Mr. HANNAM: I mentioned in the first place that the Canadian Medical Association has recommended "that the plan be compulsory for persons having an annual income below a level which proves to be insufficient to meet the costs of adequate medical care." When it comes to the matter of control and fees, the Canadian Medical Association in their presentation to the committee in June, 1942, set forth their principles. The first one is this: "That in the provinces where health insurance is established, it be administered under an independent health insurance commission, the majority of whom shall be representatives of organized medicine." Not of medical service, but "the majority of whom shall be representatives of organized medicine." That is plank No. 1. Plank No. 13 has to do with fees—"That the medical practitioners of each province be remunerated according to the method or methods of payment which they select." That is the method. Then No. 14—

Mr. HOWDEN: By the fee method, he means.

Mr. HANNAM: It does not say what it shall be, but it shall be the method that they select. That would be leaving the method to them.

Mrs. CASSELMAN: Would that "they" be the province or the doctor?

Mr. HANNAM: I will read this to you again. It reads: "That the medical practitioners of each province be remunerated according to the method or methods of payment which they select." I assume that the "they" refers back to the medical practitioners.

Mrs. CASSELMAN: It is referring to the provincial law, however.

Mr. HOWDEN: No.

Mr. CLEAVER: That would mean the method, whether it was to be a fee system, a salary system or on a per capita basis.

Mr. HOWDEN: That is right.

Mr. CLEAVER: I do not see much wrong with that.

Mr. HANNAM: No. 14 (a) "That the schedule of fees in any health insurance scheme shall be schedule of fees accepted by the organized profession in the province concerned."

Mr. DONNELLY: Do you not think that is right?

Mr. HANNAM: No. I do not.

Mr. DONNELLY: If you travel across the provinces of the dominion you will find a terrific difference now. You will find in western Canada the cost of confinement is \$35, and down in Nova Scotia you will find it is \$5 or \$10.

Mr. HANNAM: I will try to make my stand clear as soon as I read this other one. That was 14 (a). This is 14 (b): "That all schedules of fees be under complete control of the organized medical profession in each province."

Mr. DONNELLY: In the province?

Mr. HANNAM: "That all schedules of fees be under the complete control of the organized medical profession in each province." There is just one other point I want to mention. Dr. Heagerty has said before this committee, "The administration from the provincial standpoint according to this plan—the draft bill—will be conducted by a commission composed of all those participating in the plan, labour, agriculture, industry, women's organizations, the medical profession and various others, but only one man will be paid. It is headed up by a doctor, and there seems to be some justification for that." I think the last statement is one that no one quarrels with. There seems to be some justification. But to put the three things together—first, "the majority of whom shall be representatives of organized medicine", and then "all schedules of fees shall be under complete control of the organized medical profession in each province", and then that "only one man shall be paid on a commission and he shall be a doctor", is quite another thing.

The point is, as I said in my brief, that we are not in favour of this administration and control being put in the hands of one group. To put the complete control of this in the hands of one group would be the same thing some justification. But to put the three things together—first, “the majority of that board representatives of the Federation of Agriculture, and that we as the majority on the board would decide on what the prices of food would be for everybody in the country. We are not opposed, and I am not opposing doctors and medical practitioners having full representation in the plan. If they want to have the right to propose a schedule of fees and so forth, yes, but not complete control.

MR. DONNELLY: How many doctors are supposed to be on that commission? Is there only one doctor?

MR. HANNAM: Dr. Heagerty will be able to answer that.

MR. DONNELLY: How many doctors are supposed to be on that commission?

DR. HEAGERTY: There are two doctors, the chairman and the representative of the Department of Public Health *ex officio*. May I say this. Mr. Hannam has quoted the Canadian Medical Association. He has not quoted the advisory committee on health insurance. Why did we recommend that a doctor should be the chairman? Because it is only a doctor who can plan the whole thing. Every statement that has been made here this morning in regard to public health and in regard to the practice of medicine has been copied from the medical profession and the recommendations that have been made by the medical profession not only in this country but in all countries. Not one view or original idea has been brought forward in this so-called plan. There is no doubt that the layman should have representation, but not the leadership in the plan. If the layman have the leadership in the plan, we will not go where we intend to go at all; we will not know where we are going, because laymen have the tendency to swallow every health idea and suggestion that is made to them. They talked about health centres throughout the country this morning. They have accepted that without question. The committee gave a great deal of attention to the question of health centres. We followed what was said and thought and done by the planning commission of the British Medical Association. They have not recommended health centres for rural areas. Do you wish to have health centres throughout all the rural areas in Canada, in which doctors, specialists, consultants, and laboratory people will sit down and fold their arms and have nothing to do? There are not enough patients. The municipal doctor scheme, the provision of hospitals, the provision of specialists, of consultants, will solve this entire problem.

Then take one other question, the question of the plan. You have said that this is a plan, and that it is not necessary to amend the British North America Act to put this plan into effect. I submitted that plan to the Department of Justice, and justice said, “Doctor, this is not a plan.” Now, you have based your whole plan, if I may use that word, or your whole project, upon the fact that it is not necessary to amend the British North America Act. I find that many others have done the same thing in considering the post-war financing plan. They have proceeded with the thought and idea that the British North America Act will be amended. But my inquiries—and they have been extensive—have indicated to me that there is not any further desire to amend the British North America Act.

However, that is going quite a way from the thought and idea of this—that the doctors, the nurses, and the hospital groups are the people who can put in a plan, who are capable of studying all that relates to the practice of medicine and to public health. The doctor knows the practice of medicine. He knows public health. He knows nursing. He knows hospitalization. The layman guesses at it. We want the layman. We need him. We need him to

leaven the mass. We need him to represent the people, to give us their views and their ideas. But to put laymen into control may give them a whip with which to flog the professions into submission. The statement has been made this morning that areas in Canada, rural areas, are worse than in Russia in respect of medical service. I submit that community farms in Russia are almost without doctors.

Mr. FULFORD: That is true. I was there.

Dr. HEAGERTY: I submit that these statements that are made with regard to Russia are not true. There are 160,000,000 people in Russia. There are 200 languages in Russia. There is as much difference between the east end of Russia and the west end of Russia, in so far as the people and their languages are concerned, as between the people of Canada and the people of China. Russia has not got a medical system comparable at all even with our present system. Where are the instruments of war coming from in Russia? From the United States. Where are all their ideas in regard to medicine coming from? From Canada and from the United States. We lead the world in that field. Every suggestion that has been made this morning in regard to this problem of public health and medical care is to be found in the report of the advisory committee on health insurance. We have planned the whole thing in exactly the same way as has been suggested here, after a great deal of thought and consideration. We know that you cannot put into Canada one plan from one end of this country to the other that will be satisfactory. You cannot administer from Ottawa one hundred different plans. It must be left to the people themselves to say what kind of plan they want. The cost of administration of a plan from Ottawa would be financially destructive. We do not know what it would cost, but it would cost a great deal more than if the administration and the financing were to come from the province itself. Moreover, we say this. We say that in order to avoid a financial catastrophe, each province should introduce this scheme very slowly into certain areas—rural areas, urban areas, combined rural and urban areas; they should proceed slowly. We do not have to have this whole plan inside of a year. It will take time to implement the plan.

You referred to certain remarks I made in regard to the provision of services in rural areas. I said that it would not be possible at the outset to provide rural areas with the same facilities as are available in the cities. You know perfectly well that it will take years to give rural areas the same facilities as the cities have. But that does not mean that the health of the people in the rural areas will be neglected. Not at all. We cannot go out and build great health centres, great hospitals, or send masses of doctors into the country areas. The plan is not a plan at all. It is suggestions, excellent suggestions, all of which are known to the medical profession, and have been considered by the medical profession. I would suggest that, should you come back, you will discuss the recommendations that have been made by the advisory committee rather than by the Canadian Medical Association or any other group. We as a committee used our own intelligence, our own judgment. We did as this special committee has done. We called in people who had information to give us.

I am sorry I took so much of your time, Mr. Chairman.

The DEPUTY CHAIRMAN: Thank you, Dr. Heagerty.

Mr. CLEAVER: Mr. Chairman, I have two questions or rather a series of questions on two points that I should like to ask Mr. Hannam.

Mr. HANNAM: Mr. Chairman, may I refer to Dr. Heagerty's remarks before we go on to something else?

The DEPUTY CHAIRMAN: Yes.

Mr. HANNAM: I do not know why Dr. Heagerty should give us a lecture on Russia. The only reference I think I had in my paper this morning was some-

thing that was quoted from the "Radio Forum" in one community. In that case, all that Dr. Heagerty has said about Russia and about the case we were putting up, was quite out of order.

Dr. HEAGERTY: Pardon me. You submitted to the committee, "Health on the March."

Mr. HANNAM: Oh, yes.

Dr. HEAGERTY: In which you did refer very extensively to Russia.

Mr. HANNAM: That is right.

Dr. HEAGERTY: I think that may be taken as part of your brief.

Mr. HANNAM: All right.

Dr. HEAGERTY: Therefore I think I am quite within my rights.

Mr. HANNAM: I thought you said that reference was made this morning.

Dr. HEAGERTY: The reference was made this morning.

Mr. HANNAM: Well, all right.

The other point is simply this. We are not as a committee guilty of wanting to put the medical profession, the dentists and nurses in a subservient position. We do not wish that. We ask for equitable representation for all groups. We certainly know that we have use for all of their specialized services. We are entirely in favour of that. We know we cannot do it without that. But our point was simply that, in doing so, we want the plan to be administered in the interests of all the people; and by so doing, we cannot expect to have that and safeguard that if we put the entire control in the hands of the group that gives the service. That is my point.

The DEPUTY CHAIRMAN: Thank you, Mr. Hannam.

Mr. CLEAVER: Before asking my questions, I should like to say that I appreciate very much the contribution which Mr. Hannam has made, and which the Federation of Agriculture has made, to the solution of our task, and to congratulate him on the manner in which he has presented the viewpoint of rural Ontario. I do think we are all seeking the same end, and the questions which I propose to ask are not in any sense in criticism, but in an honest endeavour to try to clarify two points which he raised. I take it, Mr. Hannam, that your main objection to the Act in the present form are these. First, you are opposed to an income ceiling at which point health service would not be available under the scheme to individual earning more than a certain amount; and your second main objection to the Act is that you are opposed to any of the costs of the health services being raised by direct taxation from the individuals, or from the people of the country.

Mr. HANNAM: Direct contributions.

Mr. CLEAVER: Well, no, direct taxation. Contributions, as I read the Act, would be a compulsory levy.

Mr. HANNAM: Yes, that is right.

Mr. CLEAVER: Let me take those two points one at a time, and first take the one in regard to the income ceiling. I take it that you are fully aware that under the British North America Act the federal government has no jurisdiction to enact compulsory legislation, and that its jurisdiction is restricted to permissive legislation by way of grants, by way of monetary contribution; just as in the old age pension field we could make old age pensions available by the granting of federal money, but we could not impose an old age pension directly on the people. That being so, are you not prepared to face up to the fact that there may be some provincial legislatures which do not feel the same way about health insurance as you and I do, and who may not be willing to come in immediately for an all-out scheme under which everyone would receive the services? Are you not willing to admit that may be the case?

Mr. HANNAM: I do not think it would work out that way in practice.

Mr. CLEAVER: With regard to the old age pensions, I well remember some of the provinces did not come in for years.

Mr. MACINNIS: Order, Mr. Chairman. I think that Mr. Cleaver should ask his questions and not argue with the witness, but let him answer.

Mr. CLEAVER: This is a friendly discussion and I know that Mr. Hannam is quite capable of taking care of himself; and I know he will not be confounded by my interruptions.

Mr. JOHNSTON: But you are a lawyer.

Mr. CLEAVER: Knowing that, Mr. Hannam, would it not be much better to go as far as we can now, and to let those provinces which are willing to have an all-inclusive scheme and take in every one have the power to do that; and with regard to the others who are only willing to go part way now, to let them go the part way rather than do without altogether?

Mr. HANNAM: Mr. Chairman, I would say that our plan does not compel the provinces to come in. It sets up a national plan. The national treasury would provide the cost. If we set it up, the Canadian parliament would pass it and the Canadian parliament is representative of all the provinces, and the people have representation there. The plan is a national plan, and it is available to every province. If a province does not want to take it up, they do not have to.

Mr. DONNELLY: It does not cost them anything.

Mr. CLEAVER: That is exactly my point. The provisions in the present Act, as I read the provisions in regard to a ceiling, are permissive. They are not compulsory; they are permissive. Any province which wishes to impose a ceiling or any province which says "we will not come in unless we can impose a ceiling", is allowed to impose a ceiling, but it is purely permissive.

Mr. HANNAM: We do not want it to be permissive.

Mr. CLEAVER: All right. You do not want it to be permissive. I do not want it to be permissive. But if you find a province that wants it to be permissive, what are you going to do about it? Are you going to exclude that province from the plan entirely because they do not agree with you and do not agree with me?

Mr. HANNAM: We are putting up a proposal, a plan, for a national health insurance scheme. We believe that there are so many advantages that it shall be done in a way to cover all the Canadian people; that whatever disadvantages there may be in respect of those matters would be outbalanced by the coordinated plan doing the whole thing.

Mr. CLEAVER: I will take your answer, but I would ask you to think that thing over. Then there is the other objection. Before we leave this ceiling, however, there is just another thing. No farmer, of course, would be disintitiled to share under the health plan as a result of the ceiling you are referring to, so that agriculture would not be directly interested in that one objection to the Act. Is that not true?

Mr. HANNAM: I do not know.

Mr. CLEAVER: All right. You do not know. I do not know who would know any better than you. However, we will let that go. As to the other objection you have to the Act in its present form, as I take your objection it is this. You believe that the government should by indirect taxation—that is, by taxation not directly related to health—raise all of the money and pay all of the costs of the health services. Is that right?

Mr. HANNAM: Correct.

Mr. CLEAVER: In order to clarify our viewpoint, may I break down the costs of the health services. You have, of course heard, that it is estimated that the health services proposed under the Act will not cost more than \$30 per person per year. Is that right?

Mr. HANNAM: That is not the figure I have, but I do not know.

Mr. CLEAVER: Whatever the figure may be, then, if that figure is not correct.

Dr. HEAGERTY: There is a tentative figure of \$26.

Mr. CLEAVER: Yes. The tentative figure is \$26. Then it is proposed that the governments, federal and provincial, should contribute about one half of that. So that would cut the figure from \$26 to \$13 per person per year. Is that not so?

Some Hon. MEMBERS: Oh, no.

Mr. CLEAVER: All right. Take it that the whole \$26 is to be contributed by the person interested. Under the Act it is proposed that that whole \$26 shall not be optional, but shall be raised compulsorily from the individual, so that under the health scheme, then, every one in Canada will be a participant in health services. No one will be denied health services. Compulsory taxation will be imposed in order that they may have them. All right. In view of that fact, would you please now indicate to the committee why you think it is not wise to impose some measure of direct taxation upon the individuals benefited? Is it because they are unable to pay or what is the reason?

Mr. HANNAM: Mr. Chairman, I thought I had answered that pretty fully in my presentation. That is because of all the inequalities and all the difficulties of collecting, and all the boards of appeal and all the rest of it to decide what it should be; and because it will, in spite of anything, fall very unfairly on some families. When you say \$26, as I understand it that is \$26 for each adult above the age of 18.

Dr. HEAGERTY: Sixteen.

Mr. HANNAM: Then you have the mother, father and perhaps three of the family. In the farming community that is a very big budget. The point is not that it is impossible for many but the point is that it is impossible for large numbers; and because of the complications, the difficulty and inequity that would come in there, and of the cost of being able to collect that half of it, was the reason for our disagreement.

Mr. CLEAVER: Your point, I take it, is this. The administrative cost of collecting the money is your principal worry. Is that it??

Mr. HANNAM: Not solely. That is the largest part of it. That is one part.

The DEPUTY CHAIRMAN: May we have one more question? I think Mr. MacInnis has one.

Mr. MACINNIS: Mr. Chairman, I do not think that we can go into details. We are having these delegations before us to get their position with regard to the bill. I wish to draw attention to the fact that we have another delegation here. I wish to take objection to one point or one expression used by Dr. Heagerty. He said that we could not allow laymen to have control of this because laymen would swallow all the suggestions made to them. We are all laymen in one way or another. A man who is not a layman in the medical profession is a layman in something else. I object to being told that I am a layman and have a propensity for swallowing things; because before the doctors are finished with this bill, they will find out that we are not as gullible as all that.

Mr. FULFORD: If that were taken to its logical conclusion it would mean that a layman would be excluded from being the chairman of the board of

governors of a hospital. There is one further point I should like to make, but I do not want to take up too much time. I think one reason why doctors are reticent about setting up practices in the country is that they are excluded from many of the privileges and rights in a hospital. I know cases where doctors, young doctors, have tried to set up practices in small villages not far from larger towns where hospitals are located. They are not allowed by the local medical association to perform operations or look after intricate cases in these hospitals so they have to hand these cases over to a doctor who is recognized by the local medical association. These young doctors will be made associate doctors, but an associate doctor cannot under normal circumstances have the full facilities of the hospital. I know cases where doctors have deliberately had to move their practice from a country location into the town just so they could be associate doctors. Dr. McGarry brought that out in speaking of his own practice in Nova Scotia. That point is well taken. The answer that is given is that we cannot allow these doctors to do this work because they are not efficient, they lack experience in practice. How can they get experience in practice if they are not allowed to use those facilities? As far as doctors are concerned I think that Dr. Allan Dafoe the little country doctor, epitomizes the real spirit of the country physician. Goodness knows no one could have done a finer or greater job than did Dr. Dafoe when he brought those five little girls into the world and they all lived. It is luck that there were five girls born, but it was not luck that these five girls lived, and that was certainly to the credit of the rural doctor.

The DEPUTY CHAIRMAN: I want to thank the Canadian Federation of Agriculture for their presentation here this morning. I am sure we appreciate very much the testimony given to us by Mr. Hannam and Mr. Martin. I wish to thank their associates.

We have also this morning a presentation to be made by the Anti-Vaccination and Medical Liberty League of Canada. Mr. A. B. Farmer is to present the brief on behalf of the organization. Mr. Farmer?

Mr. A. B. FARMER, The Anti-Vaccination and Medical Liberty League of Canada, Called.

The WITNESS: Mr. Chairman, I was becoming worried for my colleague and I have left our own professional activities to come here to-day on the expectation that we would have two hours. I will have to exceed the ordinary speed limit if I am even to read this brief without comment before your time of rising, which is 1 o'clock, I believe.

I will appreciate it if you will bear with us because I am sure that our noted historian on my left will wish to have something to say about certain facts that are presented in this brief.

By Mr. Donnelly:

Q. Have you copies there?—A. I have copies, I am not sure that I have enough to go around. My notice was short, so I had to cut this little brief in sections and get 25 copies stapled up for yesterday afternoon to catch the train; as a result of that you will find some errors in it.

If I may just introduce myself in a word, many of you knew my father, the Dean of McMaster University. My interest in this subject grew out of a house to house canvass on the housing situation in Toronto in 1904. Previously to that I had no objection to vaccination or what is going on here under the head of preventive medicine.

The Anti-Vaccination and Medical Liberty League of Canada was organized in the year 1900, and chartered by the dominion government in 1927. This league exists to present, defend and advance the viewpoint of that part of the public who insist upon their right and duty.

1. To avail themselves of any method of treatment that may appeal to their best judgment, regardless of the attitude of any professional or authoritarian groups, however influential.
2. To avail themselves of the health services of persons in whom they have confidence, regardless of approval or disapproval of any government bureau.
3. To refuse to pay for or contribute towards cost of treatments which they believe detrimental.
4. To refuse for themselves and for those for whom they are responsible, methods of treatment which they believe to be detrimental.

In short, this league exists to defend and advance the same rights with regard to health and the care of the body as some of our fathers have fought for and in some measure achieved, with regard to souls.

In accordance with the purpose of its existence, this league must direct attention to certain features of proposals which have been skilfully presented and vigorously advanced before the Special Committee on Social Security, which if adopted will, in our opinion, prove highly detrimental to the health, the security and the liberty of the people of Canada.

Health, we submit, is a normal condition, a natural result of good nutrition and wholesome living.

The only real health insurance possible is to be found in wise living in wholesome surroundings. Wise living requires education, the advance and spread of knowledge of all that contributes to health. While hoping for good results from the government's nutrition campaign we believe greater results will come from greater freedom for discussion and argument on health matters. Only one school of thought is permitted over the radio these days. Control by authority in any field of knowledge is likely to halt progress. It would have been tragic if the progress of public education in nutrition had been halted by authoritarian control before the discovery of the first of the vitamins. I read a medical document seven years old which said we now know all that is necessary for nutrition.

Wholesome surroundings require public sanitation and economic security.

For the highest achievement in wholesome surroundings we have long advocated that all public health departments should be headed, not by doctors of medicine, not by specialists in sickness, but by sanitary engineers.

The gain in typhoid is on account of sanitary engineering and the improvement in tuberculosis is largely a matter of sanitary engineering and wholesome living.

Economic security requires plenty of opportunity for employment under wholesome conditions at wages sufficiently high in proportion to the cost of things to provide a generous margin for savings, and for leisure.

Any scheme of insurance to cover the costs of sickness or unemployment will become bankrupt in a long period of high prices, low wages and unemployment. Any taxes the incidence of which is such as to increase costs and prices must inevitably reduce consumption and employment.

We suggest that before embarking on any scheme that may require raising by taxation any part of the sum of \$200 millions, the government should first solve the problem of raising the huge revenue to which it is already committed, if inflation or some other form of repudiation is not to result, in a way which instead of increasing costs and reducing consumption, will tend to press the natural resources of the country into use, thus increasing and stabilizing employment at high wages, and increasing the production and reducing the costs of things.

Already we note excellent progress by private enterprise in insuring against the financial difficulties resulting from sickness, at a cost to subscribers that

compares very favourably with anything suggested as possible for a government project. We suggest that under favourable economic conditions, private enterprise will soon meet the need, and without raising the very serious issues which will be raised by the proposals which have been placed before this committee.

Sacrifice of freedom to use one's own best judgment in matters of health is too high a price to pay for any promise of financial security in sickness.

If it should be the opinion of the House of Commons that public sentiment demands some projects—the Gallup Poll indicates the public's enthusiasm is waning, you may have noticed—such as has been outlined to this committee by the Minister of Health, and so vigorously supported by a series of deputations representing various groups who expect, hope or wish to share in the \$200 millions so often mentioned, four requirements must be met:—

1. Any taxation for the support of the scheme must be such as will neither add to prices nor reduce wages and employment.
2. The chairman of every board or commission for the administration of the Act should be a layman, not a member of any group receiving payment under the Act.

At a meeting of the executive of the Federation of Agriculture I was able to learn all but two had successful and happy experience with non-medical practitioners.

3. Every citizen requiring treatment or hospital care under the Act must be free to choose treatment by any practitioner, medical or non-medical, whether at home or in any hospital receiving funds under the Act.
4. Preventive medicine under the act must be clearly defined as limited to sanitary and hygienic measures, and education, and must not include operations, medications, vaccines or serums.

1. REGARDING REVENUE

If revenue for the proposed insurance and security scheme is to be raised as revenues have been raised in the past, we fear that reduction resulting in employment and wages will do more harm than the scheme will do good.

In Croyden the government built houses to which people were forced at a little higher rent and it resulted in a higher death rate. The people needed those few shillings for food more than they needed them for better shelter.

More study of taxation incidence is required. Every member of parliament would do well to study a brief, very highly commended by Mr. N. W. Rowell, prepared for the Commission on Dominion-Provincial Relations by the Henry George Society. The suggestion of the Hon. Ian Mackenzie that in any income tax for this purpose the income of any owner of unused or unproductive property should be estimated as if the property were in fact earning a reasonable return on its capital value, may be well worth study and development.

2. REGARDING ADMINISTRATION

To place the control of large government expenditures in the hands of any group, or of persons nominated or controlled by any group who are to receive the money when it is spent, is a most dangerous policy.

In the sudden, and we hope brief, emergency of war, the government may be excused for placing the control of various branches of industry and commerce in the hands of men who have, or long had private interests in those fields. Even so, it remains to be seen how successfully their opponents may use the dissatisfaction growing out of this policy in the next election.

I speak as a one-time official Liberal candidate in Ontario.

In such a sweeping scheme as has been proposed for the control of the nation's health, the control of the administration by persons directly identified with one section of one group in the professions and services concerned, would prove unwise, and to people with traditions of freedom and public probity, intolerable.

3. REGARDING FREEDOM OF CHOICE

Fortunate mortals who have inherited such vigorous bodies, and have learned in childhood such reasonably wholesome habits that they have had no occasion to study, compare or criticize healing methods, often assume that all doctors licensed by the state are the same, and anyone assuming to help the sick without such a licence, is a fraud.

The physical and mental strain of political life is so great that a large proportion of members of any legislature are likely to belong to that class.

I speak from experience.

It is not surprising if to them even the names of some of the systems of healing or treatment should be unknown. The one group with whom they are bound to be familiar is naturally the group that has been most active in seeking to strengthen their prestige and power by legislation.

Because mankind always seeks comfort with a minimum of effort, practitioners who relieve discomforts without interfering with established habits of thinking or living, and who promise protection from disease without requiring self discipline have always been the most numerous and most prosperous, especially where wealth is concentrated. Since some patients are going to die regardless, and relatives are apt to blame the doctor, such practitioners inevitably sought to secure for themselves some legal protection. Legal protection involved legal recognition. Legal recognition and definition has its place, but when legislation is employed to suppress competition, when it makes the duty to help those whom one is able to help a legal offence, it goes too far.

The following is a partial list of the groups engaged in helping the sick:—

1. Every homemaker. The most important group of all.
2. Practical nurses. The next important group.
3. Trained nurses.
4. Midwives. We do not seem to have them in this country. The doctors seem to think they should spend their time on confinements. However, records do not throw a favourable light on that practice nor do the public altogether like it.
5. Teachers of home methods.
6. Herbalists. In every country herbalists are regarded highly by a lot of people.
7. Hydrotherapists.
8. Nutritionists.
9. Physical Culturists.
10. Masseurs.
11. Magnetic Healers.
12. Acetologists. Perhaps you have never heard of them; they are found all over the country.
13. Bonesetters.
14. Mechano-Therapists.
15. Osteopaths.
16. Chiropractors.
17. Naturopaths.
18. Mental and Spiritual Healers.
19. Chiropodists.

20. Dentists.
21. Opticians.
22. Optometrists.
23. Oculists.
24. Homeopaths.
25. Eclectics.
26. Authoritarians or "Regulars".

The authoritarians, or "regular" medical practitioners are those who believe in centralized authority and control, empowered to dictate all medical beliefs and practices. In the present century their centralized control of educational facilities and government bureau, and of related professions and hospitals, has been growing rapidly. A diminishing number of homeopaths are still licensed and in practice highly regarded and very busy. Eclectic colleges have been almost completely suppressed, and though many physicians practicing are eclectic at heart, they are being taught not to criticize those in authority.

AUTHORITARIAN CONTROL

Men of authoritarian mind have always sought to increase their power through fear. Always epidemics were blamed on neighbours. In early times they taught diseases were caused by invisible spirits which must be driven out by noises, incantations and nauseating positions. Later diseases were attributed to humors and miasms. Pasteur introduced the era of the invisible microbe, and more recently we have been introduced to the ultra-microscopic virus in the uncertain penumbra between organism and molecule. Each theory has been made the basis of campaigns of fear, and promises of relief and protection with a minimum of interference with established habits, follies and mental lethargy.

The mental defective who expects that the seed alone will insure a specific crop in his victory garden regardless of soil, cultivation and climate, may be expected to believe that specific microbes or viruses will produce diseases regardless of bodily condition and living habits.

Men of authoritarian mind love military discipline and compulsion. They have hastened to control the health services in the army and to exclude all other practitioners. The results have not been creditable. We are constantly meeting men who, originally classed as fully fit, before long had to be discharged. Published statements indicate some one hundred thousand, one in six or seven, have had to be discharged.

I met one the other day. He was inoculated and he broke out with measles and scarlet fever and they put him out of the army.

By Mr. Donnelly:

Q. Did that come from inoculation?—A. Apparently.

Q. Did it?—A. When one finds such things happening again and again one becomes suspicious.

Q. He might have got it from someone on the street.—A. In the last war, and in this war, the soldiers joining the armies of the U.S. and Canada, before going overseas, enjoyed on the average more wholesome living conditions, and activities more conducive to health, than in civil life except for one thing, inoculations. We secured official figures from Washington in 1918 and were shocked to learn that the death rate in the army at home, and not ones overseas was more than double the rate experienced by insurance companies among civilians of the same age group. The difference between 5 and 11 or 12 per 1,000 per annum is a matter of 6,000 per annum in our army in Canada. Think of it. They should have been more healthy before they got into action.

This means from six to even deaths per thousand each year among soldiers due to something unwholesome in the army which they would not have faced

in civilian life. That one thing is probably the series of vaccinations, injections and inoculations which is acknowledged to render a large number of soldiers useless for one or more days.

The U.S. Public Health Reports, April 17, 1936, show that of 1209 vaccinations investigated, 6 per cent suffered loss of time from usual activities, and 4.2 per cent caused confinement to bed for one or more days.

That is official.

Reports indicate that some of the other inoculations given the soldiers are more prostrating than vaccination.

The rush of authoritarian medical men into the army with consequent scarcity of medical doctors among the civilians, and the discharge of these thousands of thoroughly inoculated would-be soldiers, is swinging the public to the support of the non-authoritarian groups at a rate not easily guessed, but which practical politicians will do well to observe.

DOCTORS SHACKLED

The authorization group have secured for the licensed group very important privileges, the exclusive privileges of writing birth certificates, death certificates, and of treating contagious diseases. These privileges limit the rights of others.

The officer who places a handcuff on the wrist of a prisoner in his custody, frequently fastens the other on his own.

The member of any highly privileged authoritarian group surrenders some degree of his own freedom.

A medical doctor in an isolated community faced an outbreak of typhoid. Materials and facilities for the standard medical treatment were lacking. He was forced to resort to simpler treatment. Every patient was well in three weeks. Later he had to face the fact that if he followed this simpler, successful treatment and anything went wrong, he would face possible charge of malpractice.

By Mr. McCann:

Q. Where did that come from?—A. Do you wish me to name the medical doctor? He was a medical officer of health in one Ontario town for years.

Q. Name him.—A. I do not know; I have not asked his permission to give his name. He is now an old man, eighty-five years of age or more, but he was a man who was in authority and he expressed thirty years ago the view that every man who thought he could help the sick should be entitled to hang up his credentials and go to work.

Recently in Vancouver the authoritarian Medical Council barred Dr. Everly Eldon Rogers, M.D. from practice because he treated a diabetic patient with diet instead of insulin. Justice Coady of the Supreme Court suggested the case hinged on the question of whether a physician should be barred from practice for adopting a treatment he believes to be superior to the recognized methods. Dr. Rogers' name was ordered restored to the register.

4. PREVENTIVE MEDICINE MUST BE LIMITED

The term Preventive Medicine has of late been applied to two conflicting concepts.

One concept is sanitation and hygiene. Though details are controversial, the principle is sound.

The other concept is the alleged prevention of disease by the introduction into the body of products of disease. Around this concept most bitter controversy has raged for two centuries. There have been riots, fines, imprisonment, sales of chattels, bloodshed.

If any Insurance scheme should be brought into force under the control of the authoritarian medical group, and permitting them to include this concept in "Preventive Medicine", we fear there will again be riots, fines, sales of chattels, imprisonment, bloodshed. I am not joking.

This highly controversial concept of preventive medicine springs from the practice of inoculating smallpox matter on the theory that the inoculated disease will be milder than the disease acquired in normal exposure and the further assumption that a person who once has the disease will afterwards be immune.

The practice was popular with the regular medical profession for a century. Dr. Heagerty in "Smallpox and Vaccination" National Health Series No. 32, tells us of free smallpox inoculation in Quebec 1768, and how it was promoted. He also mentions what aroused the commonsense of Mr. John Public against inoculation, that sometimes fatal cases developed from inoculation of pus from mild cases. Naturally. The severity of a disease depends upon the condition of the person. Living people develop diseases. Corpses do not. It is a vital process of the living organism reacting to something that is wrong inside.

When he says "in spite" of inoculation epidemics ravaged the country, the correct word is "because". For the inoculated disease is as infectious as any other.

The amount of infective matter introduced as pus rubbed into an abrasion is enormously more than any that would be absorbed in any normal contact.

There are plenty of cases on record of persons developing smallpox a second time. The belief that one attack renders one immune is due to ignorance of probabilities.

The official report of the Medical Officer of Leicester regarding the epidemic there of 1903 shows that in that unvaccinated city, only about one case developed from one hundred chance exposures. This means that the probability of a person developing a second case is one in ten thousand.

The Leicester report notes among others—if we had plenty of time, I have one report here—the case of a girl who sat in the out-patient department for three hours with the smallpox eruption upon her. There were as many as 100 other patients in the room with her at one time, practically all the younger ones unvaccinated—those born since 1885. The only person who contracted the disease was one woman who had been vaccinated and sat near her. That is official.

Popular opposition to inoculation prepared the way for the medical switch to vaccination, enforced with compulsory laws, ultimately relaxed in England in 1898 and further in 1908.

From 1871 to 1880 over 85 per cent of the children born in England were vaccinated, and the death rate from smallpox was 288 per million living. From 1931 to 1940 only 36 per cent were vaccinated, and the rate from smallpox was—not 288 per million, but 4 per hundred million. The more people who forget vaccination and keep clean, the less smallpox.

GOOD NEIGHBOURS

Certain statements made in the booklet issued by the Dominion Department of Health, National Health series No. 32 call for explanation. We select a few.

On page 16 the 1924 epidemic in Windsor is blamed on the neglect of vaccination in Michigan, as a result of which "smallpox is frequently present in that state." Figures are quoted for smallpox cases in Detroit in 1920 and 1921. The fact—and I have this in figures just received from the Department of Health of Detroit for the last twenty-one years—that in nineteen of the twenty-one years since 1921, there were no deaths from smallpox in Detroit, is ignored.

On page 18 it is stated that in Windsor there were 67 cases, with 32 deaths in 1924. This appalling death rate calls for explanation. In Detroit the same year there were 163 deaths out of 1,610 cases. This is high, considering that in the nineteen of the last 21 years there were 567 cases and no deaths in Detroit.

I should like the vaccinators to explain that.

Dr. HEAGERTY: We will.

The WITNESS: Continuing:

A description of the treatment used in the Detroit hospital published in the monthly bulletin of the Detroit Department of Health for April-May, 1925, which shows that in addition to other dangerous treatments, all cases taken to the hospital were vaccinated, may explain this very high death rate in Detroit.

What must have been the treatment of smallpox in Windsor? Or could it have been that the fatality was no greater in Windsor, but there were at least 320 instead of 67 cases, the others unreported or undiagnosed? Or were they treated illegally but successfully by drugless practitioners? Perhaps you can think of other explanations.

In the rest of Ontario that year there were 532 cases and only 15 deaths. Again, why?

One fatal case, William Montgomery, died in Toronto. As soon as he was diagnosed, the other members of the household were vaccinated and permitted to go about their affairs. Of eight persons, four—two vaccinated and two re-vaccinated—went down with smallpox. The facts were published in the *Toronto Daily Star*, March 22, 1924. A vaccination smallpox scare being worked up promptly subsided. We had no epidemic in Toronto.

Surely doctors and nurses learned something from 1904 to 1924. Yet in 1904 unvaccinated Leicester had a smallpox epidemic. There were all of four deaths out of 321 cases. I have the official report with me.

In Toronto towards the end of 1919 there were some cases diagnosed as smallpox. In all there were fifteen deaths certified as smallpox. We investigated some fifteen deaths reported by the families as due to vaccination, though not so certified. The epidemic vanished as if by magic when the application by the provincial Board of Health for a mandamus to compel the City Council to enforce general vaccination was thrown out on a technicality by the Supreme Court. That was between Christmas and New Years.

On page 20 the statement is made that sanitation and isolation alone do not eradicate smallpox. That statement is contradicted by the experience of Leicester, and by the experience of states in the American Union where positive laws prohibit compulsory vaccination. The 1919 and 1924 Toronto experiences suggest a wise court decision, and publication of facts by a newspaper may help.

The general death rate in Michigan for sixteen years was almost exactly the same as that of Ontario, but the five years 1938-42, was 9.8 to Ontario's 10.1. The infant death rate the last five years was 44.8 in Ontario, only 40.7 in Michigan. It looks as if neglect of vaccination is associated with better health.

Minnesota is considered a notorious centre of anti-vaccinationist activities. The total death rate the past five years averaged 9.6 and in Ontario 10.1. The average infant death rate Minnesota 34.4, Ontario 44.8. Perhaps anti-vaccinist Minnesota can teach Ontario something.

In Utah, where to many citizens healthful living is a religious duty, there has long been a strong law prohibiting compulsory vaccination. The average death rate the past five years was 8.3, far better than Ontario's boasted 10.1, and the infant death rate 37.9 against Ontario's 44.8.

Health intelligence appears to be related to opposition to vaccination.

VACCINATION DANGEROUS

Medical literature may, we believe, be searched in vain for particulars regarding the exact relationship between the virus of vaccine and that of smallpox.

No method has yet been devised for separating out the viruses in any sample of pus.

Manufacturers of vaccine have bitterly opposed laws introduced from time to time to require a guarantee of complete freedom of their vaccine even from bacteria.

Farmer's Bulletin No. 666, U.S. Department of Agriculture, some years ago, 1915 it was, gave particulars of an epidemic of foot and mouth disease, traced by U.S. government investigators to calves used by Parke Davis & Co. of Detroit to produce vaccine and which cost the federal government \$5 millions to stamp out. I understand the total cost of that epidemic definitely and authoritatively traced to vaccine was \$9 millions. The Henry Mulford Company also used the same strain of vaccine—it was from them the Parke Davis Company got it, but the foot and mouth disease was not discovered because Mulford destroyed their calves instead of returning them to the farms. A book published by Chas. M. Higgins, the N.Y. ink manufacturer shows pictures and reproduces affidavits regarding some of the effects of this lot of vaccine on people.

Recent research indicates that the virus of smallpox measures just a trifle less than the spirochete of syphilis, and about twenty-five times the size of the virus of foot and mouth disease. Not easy to separate, ultra microscopic. No report at hand regarding the virus of cow pox.

Recently an order seems to have been issued that Canadian soldiers shall be given a blood test for syphilis before receiving their inoculations. Why? Because U.S. Government investigations have shown that a person after vaccination is apt to give a positive syphilitic reaction for a long time. Whatever the exact meaning or value of the blood tests, they do show that vaccination and syphilis make something the same kind of mess of the blood.

In Britain for more than forty years the deaths from vaccination, so acknowledged in death certificates written by doctors for the most part committed to vaccination, reported to the British House of Commons in answer to questions by members, have exceeded the deaths from smallpox, though the number of vaccinations has steadily declined.

Sir William Osler, in "Principles and Practice of Medicine" acknowledges that "A quiescent malady may be lighted into activity by vaccination." Why risk lighting it up? Who can tell what malady may be quiescent? And who cares?

DIPHTHERIA AND TOXOID

We turn now to National Health Series No. 108, "Prevention of Diphtheria."

This booklet traces the history of diphtheria to its earliest description by Pierre Bretonneau, 1826. It neglects to add that Bretonneau relates it causally to the practice of vaccination recently introduced.

A survey of statistics of area after area shows that almost invariably, wherever vaccination is trusted or enforced, an increase of diphtheria cases and deaths follows a smallpox scare. The exceptions we find where vaccination is neglected—Leicester for example in 1904, where with 321 cases of smallpox in a population of 225,000 less than 3,000 persons were vaccinated. Compare that with 50,000 in Windsor.

The booklet mentions, page 7, that one attack of diphtheria does not automatically protect, since the toxin produced is not always sufficient to stimulate adequate anti-toxin. That might be true if the patient is treated with anti-toxin, not if the patient is treated with drugless methods.

I have yet to hear of a second attack of a patient treated by drugless methods.

Mr. HOWDEN: They do not live long enough.

The WITNESS: That is an absolute falsehood. I have never heard of one dying.

Mr. HOWDEN: My dear friend, there was a mortality for years of 86 per cent in diphtheria cases until anti-toxin was produced, when it was reduced to 8 per cent.

The WITNESS: That was not under drugless methods. Those were regular medical patients.

Mr. HOWDEN: When they got no drugs at all, they just died. That is all.

The WITNESS: I have seen a case come through—a child between four and five, with older and younger children in the family—without a drop of medicine of any kind.

Mr. HOWDEN: How did you know it was diphtheria? Did they take any swabs?

The WITNESS: I saw it.

Mr. HOWDEN: How did they diagnose it was diphtheria without a swab being taken?

The WITNESS: Now you are changing the whole basis of diagnosis of diphtheria for a century. We did not take a swab. But the characteristics of the diphtheric membrane are fairly clear and definite to anybody with eyes.

Mr. HOWDEN: You cannot tell it from Ludwig's angina and a lot of other things.

The WITNESS: The rest of the family did not develop a sneeze, and in three weeks the child was at a party.

Mr. HOWDEN: That is a pretty good indication that it was not diphtheria.

The WITNESS: Of course, you may make a definition that unless there is such a percentage of deaths, it is not diphtheria; then we will have to change our definition. Continuing:

The immunity conferred by toxoid is set, page 10, at 80 per cent to 98 per cent of the children treated, and is claimed to become effective within three months. Too slow.

Says the booklet, "Anti-toxin will invariably effect a cure if given soon enough." Why the increasing percentage of deaths to cases, 15 out of 143 in 1942, 10.5 per cent against an average of 4.7 per cent in 1929?

When after some years of vigorous toxoid propaganda Toronto had one year, 1940, without a case or death reported from diphtheria, the news was broadcast to the world as proof of the effectiveness of toxoid. In Toronto the practice is to give each child three toxoid injections to insure immunity. The best information available indicates that at no time have 40 per cent of the children been immunized. Must not 40 per cent of the children be given credit for eliminating the disease for a year? After a while, they will do just as they did in the days of Moloch, where the burning of one child might wipe out an epidemic. Yet in 1943, the British Minister of Health broadcast over B.B.C. an appeal for toxoid, using Toronto as an example. He neglected to mention that in the first nine months of 1942 Toronto had 52 cases with 7 deaths, a shocking death rate of 13.4 per hundred. They were not in drugless hands at all. That would have been front-page news.

If any drugless practitioner lost a case of diphtheria, that would be front-page news. When the late Dr. Walter Hadwen, M.D., in England, lost a case on which he did not use anti-toxin, he was charged with manslaughter. His acquittal was received with great enthusiasm.

ABOUT CONTAGION

We suggest that if vaccination and toxoid modify or ameliorate the diseases for which they are given, they increase the difficulty of checking the disease, increasing the number of carriers.

We suggest that confidence in the efficacy of vaccination and toxoid results in failure to diagnose and report many mild cases.

COST OF TOXOID

A deputation from the Canadian Public Health Association is reported to have stated that in Ontario in 1924 there were 322 diphtheria deaths, which cost an estimated \$300,000 or nearly \$950 per death, while to toxoid all the pre-school children would have cost only one-third. Let's figure.

To keep pre-school children toxoided at that rate would cost \$20,000 per year, in five years, \$100,000.

The past five years there have been only 53 deaths, costing the same ratio only \$50,000. All the children of Ontario have not been made more or less ill three times.

In the light of the recent disaster at Neepawa, one airman dead and eleven in hospital, the danger of toxoid cannot be denied.

COST OF SMALLPOX AND VACCINATION

The official publication already quoted estimates the cost of the Windsor smallpox epidemic of 1924 at \$35,000, or \$522 per case reported.

The cost of the Leicester epidemic of 1904, with 321 cases and only four deaths, was approximately \$27 per case.

The booklet says in two weeks 50,000 people in and around Windsor were vaccinated. The vaccinations in Leicester in 1904 were less than 3,000 in a population of 225,000.

THE RELIGIOUS ASPECT

Back of the rules regarding cleanliness in the Mosaic law is a recognition of the possibility of contagion through discharges from a diseased person.

The introduction into an abrasion or puncture in the skin of matter from a diseased animal goes directly contrary to the principle behind the Mosaic rules.

Paul calls the human body the Temple of God. Some Christians consider it their duty to treat the body as such, and accordingly to care for it and keep it clean. The idea of introducing material from a sore, or from the blood of a diseased or poisoned animal is to such persons repugnant.

Of course, vaccine is not poison, but recently when they had a little scare in Pennsylvania I have a report of three medical men who scratched themselves with vaccine points in the rush for vaccination and had to have hospital treatment for blood poisoning.

Religious persons are usually peaceable. This attitude is not publicly proclaimed except by a few minor sects. I am a good hard-shelled Baptist myself. But the Bible is in the hands of most people, and some sincere souls are influenced by these teachings.

History teaches that religious people are of all people the most obstinate. To force inoculations and vaccinations on people who object and whose objection however described may well have a religious root, is unwise. Nor is it well to forget that Jesus of Nazareth was an unlicensed teacher and healer. He was not a graduate of accredited schools as either teacher or healer. It is unwise to enact laws and establish departments that would hasten him again to the courts if he were to reappear and quietly resume the teaching and healing he started nineteen centuries ago.

CONCLUSION

In conclusion:

The facts noted above are only a very small fraction of evidence available, to show:—

That vaccinations and inoculations are dangerous.

That confidence in vaccinations and inoculations increase the difficulty of controlling diseases.

That generally health conditions have improved along with neglect of these methods, and are best in those areas where opposition is strongest.

I notice that the Alberta death rate, where we heard such terrible things as the result of the lack of medical care, is almost 3 per thousand lower than Ontario where I guess we have the best medical care in the dominion.

Continuing:

The objections to these methods are multiplied with the number of diseases against which protection is sought.

Heinz Leipmann, in his excellent book, "Poison from the Air"—in his chapter on bacterial warfare, based on information gathered in all the capitals of Europe where preparations were being made prior to 1937, observes as a simple matter of experience, that where a person is inoculated against a number of diseases, only one is effective, and since there are many varieties of one species, such as streptococcus, such protection is practically useless.

We may then emphasize again that the best health insurance is wise living under wholesome conditions.

This requires plenty of employment at high wages with low prices of things, and the spread of knowledge of hygienic living.

Any health insurance plan to be acceptable must assure the right of the citizen to avail himself of the practitioner of his choice, medical or non-medical, and of the method of treatment of his choice, whether in hospital or at home.

Preventive medicine must be defined to include only sanitary and hygienic measures, and to exclude all vaccines, serums and inoculations.

Remove interferences with the use of natural resources, with the production and exchange of goods and services, remove interferences with freedom of discussion and controversy, and you will do more for the health and security of Canada than can be accomplished by any elaborate and expensive scheme controlled by one privileged group in the field of healing.

The DEPUTY CHAIRMAN: Thank you, Mr. Farmer.

Dr. HEAGERTY: Mr. Chairman, at the outset of his remarks, Mr. Farmer turned to me and referred to me as a historian. That is quite true. I have written some volumes on the subject of the history of medicine in Canada. I sincerely hope that Mr. Farmer will read those volumes at some time. He has quoted some pamphlets that I have written. Here is a statement that I should like to refer to. He says, "Dr. Heagerty in 'Smallpox and Vaccinations' National Health Series No. 32, tells us of free smallpox inoculation in Quebec in 1768, and how it was promoted. He also mentions what aroused the common sense of Mr. John Public against inoculation, that sometimes fatal cases developed from inoculation of pus from mild cases." I want it to be understood that this referred to inoculation with smallpox.

The WITNESS: Absolutely.

Dr. HEAGERTY: The death rate throughout Europe and the death rate in the province of Quebec was so great from smallpox that the people had recourse to any method that would reduce that rate. It was found that inoculation with a mild type of smallpox would do just that. But sometimes the type of smallpox was not mild—that type that was used—with the result that epidemics occurred. So I must point out therefore that he is not dealing with vaccination

with cowpox. From the time that vaccination with cowpox was introduced into Canada, smallpox almost disappeared. In 1702 one-third of the entire population of the city of Quebec—there were 9,000 people at that time—died from smallpox. That was before the introduction of vaccination.

He has mentioned diphtheria and other diseases. And if he will go back to the figures that I have quoted of earlier days in Canada he, I am sure, will be extremely shocked to find that before we had a medical profession, a nursing profession, hospitals and a knowledge of the cause of disease and inoculative procedures, the death rates were most extreme, if I may be permitted to use that word.

May I suggest, Mr. Farmer, that you go back and read these figures?

Mr. FARMER: Perhaps I can give you another answer to that, Dr. Heagerty. In the early days the food supplies were very limited, as you know.

Dr. HEAGERTY: No, I disagree, there was plenty.

Mr. FARMER: In this sense: diphtheria is a disease that is most frequent, I believe, in the winter and spring.

Dr. HEAGERTY: No, I am in disagreement with you there; it occurs chiefly when the children get together in school, one affects the other.

Mr. FARMER: My mother died a few years ago at the age of seventy-seven, and never saw a case of diphtheria.

Dr. HEAGERTY: Your mother was not a doctor.

Mr. FARMER: No, she was a woman who had lived in Nova Scotia and Ontario and raised quite a large family; none of us had toxoid or anti-toxin or any of it. There are some researches that I can think of which show that a proper diet and adequate supply of food rich in the "C" vitamin has a great deal to do with keeping a person free from conditions that are associated with diphtheria. That is confirmed by my own experience in watching a good many cases in the past ten years.

Mr. HOWDEN: Mr. Chairman, I think we are wasting time in pursuing an argument of this type any further. Such rot as we listened to this morning is just simply a waste of time, that is all.

Mr. McINNIS: I do not think we should insult a delegation that comes here. We have just as much right or anyone else to call what the medical profession said here rot, but I am sure that there would be quite an explosion here if someone got up and said that the report which was brought in by the medical council was rot. We have to be tolerant, otherwise we are merely proving the statement made by the gentleman who spoke to us this morning. He made a statement and it is for us to agree with him or not, and we should not label it as rot.

Mr. HOWDEN: At this time, after fifty years of experience on the part of the intelligent public officials of the world at large as to the beneficial results that have been discovered and brought about by the science of medicine in the intervening time one must realize the fallacy of the arguments that have been presented to us this morning.

In that connection I may say that I remember when whole families were wiped out with diphtheria. I can think of epidemics when many families were wiped out by diphtheria, every child in the family wiped out. I can remember before we thought of using serum for the virulent forms of scarlet fever where whole families would be wiped out by the disease. I have seen five or six children laid out for burial at one time. And I want to tell the committee this morning it was only after the discovery of the diphtheric anti-toxin for scarlet fever that we were able to stop that, just the same as we have stopped diphtheria. There is no question about it in the world.

Mr. FARMER: Mr. Chairman, I give my worthy friend here all credit for sincerity and truthfulness, but I am here to say that there are other means and other methods of treating these things that also are very successful though he has apparently had no contact with them.

The CHAIRMAN: Are there any further questions?

Mr. A. B. DAVIES: May I say one or two words?

The DEPUTY CHAIRMAN: Yes.

The WITNESS: Pardon me. My colleague is Mr. Davies. His English, as you will recognize, is not quite English. He comes from the middle east where he learned natural methods which he has brought to Canada. He has been here only about twenty years. He has made very many friends, has a very large practice in Hamilton, and is highly regarded by a great many intelligent people.

Mr. DAVIES: Mr. Chairman and honourable members of the committee, as my colleague, Mr. Farmer, remarked, not only is the language that I am attempting to use not my native tongue, but I have never studied formally at school. Therefore I would ask you to kindly be tolerant and give consideration to what is being said rather than to the manner in which it is said.

I should like, if you will permit me to do so, to bring to the consideration of the committee just a few points on the principal factors with regard to this health Act which, owing to the press of time, my colleague, Mr. Farmer, was not able to enlarge upon.

I certainly agree with the principle that our status quo in health matters is far from being satisfactory. As Hon. Mr. George Hoadley has so aptly put it, the figures, when you consider them, are really appalling. You gentlemen have a task to perform, that of giving the Canadian public something that will be better than what it has had before. The intent of the Ministry of Health and of the advisory committee, I am sure, has always been for the betterment of the public welfare. However, good intentions do not always lead to the best results. We are told that even Adolph Hitler has always been sincere, as far as his convictions are concerned, thinking and believing that he is serving the public.

Now we have before us, honourable gentlemen, a tentative pile of suggestions as to what must, should and will be accomplished. But when it comes to a matter of asking the public, or the leaders of the public, to invest the fabulous sum of \$240,000,000 annually, naturally it is our duty to see that a concrete, workable and worthwhile plan is offered as a basis of that investment. I regret, although valuable statements have been made by witnesses who have testified here, mention has never been made of one.

What was it that led to the planning of the present draft bill on health insurance? It was recognition of the fact that the Canadian public is not healthy; and an attempt is being made to make it healthy and to keep it healthy. With regard to that, gentlemen, may I say this with all sincerity. How are we going to make our nation healthy when, as I said, no definite concrete plan of any kind has ever been offered; and as far as I have read of the testimonials of all the witnesses, I regret to say that there was not one single statement with regard to what health is. Health may be defined in this way, gentlemen. It is a natural gift. Health is a natural condition of the human being so long as there is first no foreign agent in active manifestation in that system; and second, so long as the four channels of reception and the six channels of elimination of the human body are functioning harmoniously. Those four channels of reception are: (1) breathing; (2) eating and drinking; (3) the receiving of sunshine and air through the pores; and (4) electricity through the head which is conveyed to the brain and through the brain into the spinal column and distributed through the system, which makes possible every movement that we make.

The six channels of elimination are these: first, what we throw out of the system by exhaling, by expiration—carbon dioxide, which is the largest amount of toxic organic poison; second, we come to bowel elimination or faeces; third, urin; fourth, sweat or perspiration, which is the result of activities of the lymphatic system.

No. 5 is the mucous elimination which takes place in relieving the brain of the accumulated matter in the brain through the nose and the organic poisons or toxins accumulated in the spine through the genitalia. Then we have the sixth elimination channel, which I am sorry to say is mentioned very little, if at all, in the medical books or authorities. The sixth one is the very important thing which now is the basis of that terrible disease which is called poliomyelitis. That is, the non-use of electricity through the feet because of lack of contact with the ground due to the wearing of rubber soled shoes and so forth. So as long as these things are in existence, honourable gentlemen, health is impossible irrespective of what we may do by inducing infection into the human system. We cannot make it healthy, we only aggravate the disease condition because it only stands to reason that poison when induced into the system—you can consult any standard dictionary you want and you will find this—when poison is introduced into the system whether organic poison or poison it always has the effect of creating or producing a condition of morbidity. Therefore, may I take this opportunity to say two things, honourable gentlemen, we are deploring the lack of adequate means of coping with mental conditions. If I have your permission I can offer you a plan whereby within a decade or so we can reduce our medical cases down to practically nothing. It is a very simple method; likewise with that dreaded disease cancer, which I consider fundamentally is produced by vaccination which checks the organic poisoning and the time comes when the lymphatic glands are so tired at holding these poisons that they break down and the growth is started.

Now I personally have treated approximately 700 or 800 cases, but my cures, I am sorry to say, have never exceeded more than 65 per cent, but over 85 per cent of amelioration or benefit has been obtained. At one time, it is true, I tried to interest the medical profession in this, but unfortunately they took me into court and I was fined for all the efforts I had put forth.

Now, Mr. Chairman and honourable gentlemen, I take this opportunity of saying that if you are willing to accept the co-operation of non-medical helpers—pardon me, do not misunderstand me when I say “helpers,” because all that I offer is free of charge—I, as well as my colleagues, will be glad to do that to make our country a healthier place for everybody to live in.

Mr. SHAW: Mr. Chairman, I should like to make one observation. I see about five members of our committee present. I do not know whether the gentlemen back there are medical men or not, but this does not indicate tolerance, freedom of expression, or freedom of thought. We have permitted these men to appear, and personally, I am thoroughly disgusted with the consideration which we as a committee have given them. I say, Mr. Chairman, that if this is to be our attitude I, personally, do not want anything more to do with the deliberations of this committee.

Mr. JOHNSTON: I want to go on record as supporting Mr. Shaw's view. I think we are here primarily to hear the evidence of these witnesses and it is our duty to be as courteous to one group as another, and I certainly wish to associate myself with the views expressed by Mr. Shaw.

The CHAIRMAN: The representations made have been duly recorded. It is unfortunate that we have not a larger number of members here at the moment, but when Mr. Farmer began to testify he sent me a note saying that he would take about thirty-five minutes to read his brief, and I think Mr. Farmer began about 25 minutes to 1, and it is now 15 minutes to 2.

Mr. FARMER: I think my actual reading took about 35 minutes.

The CHAIRMAN: You figured you would take until about 10 minutes past 1.

Mr. FARMER: I appreciate your remarks.

The CHAIRMAN: We will adjourn until tomorrow morning at 11 o'clock.

The committee adjourned to meet Friday, June 11 at 11 o'clock a.m.

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(SESSION 1943)

(HOUSE OF COMMONS)

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(SPECIAL COMMITTEE)

ON

(SOCIAL SECURITY)

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 20

FRIDAY, JUNE 11, 1943

WITNESS:

Rev. Fr. Emile Bouvier, S.J., representing the Catholic Hospitals of Canada.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

FRIDAY, June 11th, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Mr. J. A. Blanchette, the Vice-Chairman, presided.

The following members were present:—Messrs.: Adamson, Blanchette, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Howden, Johnston (*Bow River*), Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon, Macmillan, McGarry, McGregor, Picard, Shaw, Warren and Wright.—22.

Rev. Fr. Emile Bouvier, S.J., Director of Industrial Relations and Professor of Social Legislation of the School of Social Service, University of Montreal, was called. He presented a brief on behalf of the Catholic Hospital Council of Canada, was examined and retired.

Mr. Blanchette tendered the thanks of the Committee to the witness.

Mr. Fauteux requested that witnesses be called to give evidence respecting slum clearance. He was advised that this would be considered.

The Committee adjourned at 12.30 p.m. to meet again Tuesday, June 15th, at 11.00 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.



MINUTES OF EVIDENCE

HOUSE OF COMMONS, June 11, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Deputy Chairman Mr. J. A. Blanchette, presided.

The DEPUTY CHAIRMAN: Gentlemen, as was announced yesterday we have with us this morning the Rev. Pere Emile Bouvier, S.J., who represents the Catholic hospitals of Canada. The Rev. Father Bouvier is Director of Industrial Relations and Professor of Social Legislation of the School of Social Service in the University of Montreal, and he is appearing before you to-day in the capacity of chairman of the Health Insurance Committee of the Catholic Hospital Council of Canada. I understand that Father Bouvier will testify for the most part in English with a few remarks in French afterwards.

I shall now call Father Bouvier.

Rev. Father EMILE BOUVIER, S.J., called.

The WITNESS: Mr. Chairman, Hon. Mr. Mackenzie, and gentlemen: The Catholic Hospital Council of Canada deeply appreciates this opportunity of appearing before the Special Committee on Social Security of the House of Commons. Health insurance is a problem of major importance not only for the restoration of the health of the people but also because of the principles involved and the special character of this Catholic Hospital Council of Canada. In fact, as soon as it was known that health insurance was to become a reality, the executive board of the Catholic Hospitals of Canada called a meeting in Toronto in October 1942, and created a health insurance committee of nine members to study the incidence of such a legislation on the Catholic hospitals. The committee has made a very careful and impartial study of the problem and has laid down certain principles guiding the Catholic hospitals in their attitude towards such new legislation.

You will forgive me, Mr. Chairman, if I bring in considerations which at first blush might seem irrelevant. I am prompted to do so first because I am addressing an audience at once open-minded and competent in this specialized field, an audience therefore desirous to hear a frank exposition of our viewpoint and of the motives behind it. Again I am urged to bring in these apparent irrelevancies because they are in reality a whole historical and philosophical background, an integrated view of life in the light of which we judge even a health insurance act. My brief then breaks up logically into the following divisions:—

1. The special character of our Catholic hospitals.
2. Our philosophy of health insurance.
3. The problem of coverage.
4. The contributory system.
5. The problem of health centres.
6. The problem of nursing and representation.

1. SPECIAL CHARACTER OF THE CATHOLIC HOSPITALS

In the early church, care of the sick was a most important duty which was first imposed on bishops, then on priests and deacons. The bishop was by his office a host to strangers and to the sick. When the bishop's palace was overcrowded wealthy Christians opened the doors of their large and spacious homes. It was only in 325, when the peace of Constantine was signed, that Catholics

thought it advisable to create hospitals. In fact, due to a lack of public hygiene, the sick became so numerous that such an institution was necessary. The building of such hospitals by the fathers of the church was a crystallization or rather an extension of the charity of the first Christians. Hospitals, special clinics, residences for doctors and nurses sprang up rapidly all over Europe. The crusaders opened the doors of the east: economic and social expansion had developed more urban areas and increased the population. Charity developed more and more. Individuals, groups, guilds, and municipalities, built hospitals. Milan erected 11 hospitals, Florence, 30; certain German cities, 8, 9, 16.

In 1545, all the bishops and archbishops of the world were assembled at Trent. Among many problems of vital importance, came the problem of hospitals. Naturally the church must not only teach but also legislate on questions of morals and discipline. In hospitals, many problems are of a moral nature. Abortion, sterilization, illicit operations, for example, are all condemned by the Catholic church. Hence a hospital claiming to be Catholic, must submit to the Church's teaching in this respect.

Therefore, the Council of Trent resolved to place the Catholic hospitals under the spiritual jurisdiction of the bishops and proclaimed the right of the bishop to visit the institution and to supervise its moral administration.

In France, the control of hospitals belonged to the king: Louis XIV transferred his jurisdiction to the bishops. This same rule still appears in Canon Law. According to Canon 1489 "Local Ordinaries may erect hospitals. . . and similar institutions destined for religious or charitable works; they may also endow such institutions with the character of ecclesiastical corporations".

But the most important fact linking the sisters to the church is that their ecclesiastical superiors are bishops. Hence, all their lives, actions and deeds in temporal and spiritual matters are dependent on the will of their respective superiors who hold for them the place of Almighty God.

History records the importance of the part played by the sisters in the beginnings of Canada. At the very foundation of Quebec and Montreal, they were associated with the missionaries and the great explorers. They spent their lives in works of charity and zeal and gave all their time to relieve the sufferings of mankind. Their activity is explained neither by ambition nor by a desire for gain but only by the highest motives of love and charity. Hospitals, asylums, sanatoria, were built upon a solid foundation of supernatural love for their neighbour. It was with this spirit, as you are all aware, that the first hospital in Canada was founded in Quebec by the Duchess of Aiguillon in 1639. Jeanne Mance opened the Hotel Dieu of Montreal in 1644, and, for a great many years afterwards, the hospitals were operated by religious congregations.

Today, sisters are taking care of Catholic hospitals scattered through Canada from Vancouver to Halifax, including the first Hotel Dieu in Quebec and Montreal and their most modern counterpart elsewhere. Sisters of all kinds have entered the field: Hospitalières of St. Joseph, Grey Nuns, Sisters of Providence, Sisters of Charity, Sisters of St. Augustine and a great number of others. . .

With the social and economic development of Canada, secular hospitals were erected whose direction was independent of the Church.

Therefore, it was necessary for the nuns and sisters to group themselves in an association through which they could obtain sound advice and direction particularly in matters connected with social, moral and spiritual issues. They united with the Catholic Hospitals Association of the United States and Canada. Recently they formed the Catholic Hospital Council of Canada which is their official organization.

The Catholic Hospital Council of Canada is an association of Catholic hospitals owned, conducted or serviced by nuns or sisters under the jurisdiction of the Canadian hierarchy.

The dominion is divided into regional sections called "conferences" and the federation of these conferences constitutes the Catholic Hospital Council of

Canada. At present, there are six conferences: the Maritimes, Quebec, Montreal, Ontario, the Prairies and British Columbia. These conferences include 184 hospitals with more than 22,000 beds.

The purpose of this association is to advise the sisters of Canada on religious, social and economic questions affecting the hospitals. As the religious hospitals are under the jurisdiction of the archbishops and bishops of Canada, it is of importance for the nuns to have an organization interpreting the desires of their excellencies.

When the problem of health insurance came up for serious discussion in Ottawa, the executive board of the Catholic Hospital Council of Canada thought it advisable to study this important problem in order to know what attitude to take.

Hence, a meeting was called in Toronto in October, 1942, and a committee was appointed to study the matter carefully and to report to the Bishop's committee composed of their Excellencies Archbishop Vachon of Ottawa, Archbishop McNally of Halifax and Archbishop Carroll of Calgary.

2. ESSENTIAL PRINCIPLES AND HEALTH INSURANCE

Every informed Canadian is fully aware of the health situation of Canada. Infant and maternal mortality, causes of deaths, communicable diseases and consequent mortality make a very sad statistical picture for public health in Canada. The evidence has already been given to this committee by Dr. Heagerty in his report to the advisory committee, March, 1943, part V, pp. 181-378, to which I refer.

On the other hand, wage-earners receive low wages. In 1941, 33.4 per cent of breadwinners in urban areas and 72.9 per cent of other workers receive less than \$1,000 a year; in rural areas, 59.7 per cent of breadwinners and 89.1 per cent of other workers receive less than \$1,000 a year. As for women, 88.2 per cent in urban areas and 96.5 per cent in rural areas receive less than \$1,000 a year.

With such need of medical services on one side and such low incomes on the other, some action must be taken. How could we remedy this situation?

The logical way to cope with this problem is to complete the deficiency in wages by social insurance. By social insurance the workers pool certain resources in order to face certain risks of life like unemployment, old age and sickness. We might, in theory, give to the worker a wage rate which would cover these risks but unfortunately economic and industrial conditions do not allow such a wage. Hence the necessity to protect the worker through social security. This necessity has its fundamental basis in justice and charity.

This protection follows from the right to a living wage. If by God's law, man must work for his subsistence and the subsistence of his family, society, on the other hand, must see that individuals are able to provide for themselves and their families. The necessity of social insurance follows from the teaching of Pope Pius XI in his Encyclical *Divini Redemptoris*: "According to Social Justice, the wages should secure the workers subsistence and the subsistence of their family. The system should permit the wage-earners to receive from their work a sufficient income in order to resist general poverty, which is a true calamity. A system of social or private insurances should protect them in time of old age, sickness or unemployment."

Having recognized that social insurance is justified on grounds of moral philosophy, our committee proposed a first question: "To remedy the present health conditions of the Canadian people, should social insurance be realized on a voluntary or on a state, compulsory basis?"

The voluntary plan is a regime of health insurance realized by a free pooling of resources to cope with a definite risk. For health it may take the form: (a) of cooperative medicine, (b) of group hospital plan, (c) of voluntary health insurance.

(a) Cooperative medicine is a voluntary, non-profit organization in which members group themselves to get medical services at cost. It has four guiding principles: medical practice, preventive medicine, regular fees or contributions and control by the members themselves. The United States and Europe have realized such a plan. The cooperative medicine of LaHaye called "Volharding", established in 1882, numbers now more than 118,000 members paying \$5.20 a year. It has now 22 doctors, 9 specialists, 12 dentists, 2 druggists, 14 assistants in the drug business, 26 nurses, 15 visiting nurses and 12 chauffeurs for ambulances. It has a general hospital, a polyclinic, a dental clinic and 2 drug-stores. The salaries for doctors vary from \$2,400 to \$5,600. When surpluses exceed expenditures they are used for survivor's benefits, preventive measures and summer camps. Add to this, "l'Union des coopérateurs" in Paris, les "Œuvres Mutualistes" in Brussels, and finally the Elk City experiment in Oklahoma.

(b) The second form is the hospital group plan well known by its founder Dr. Millican and popular in Manitoba, Ontario, Quebec and, it seems, in Nova Scotia. The New York plan numbers half a million members already.

(c) In the voluntary plan, workers and employers contribute their share to a pool in order to help the worker to cover sickness risks. There are two types: the open fund where any individual may contribute and the closed fund recruiting members of the same industry or of the same craft or of the same political party or of the same religion. These funds were popular in Belgium while the open funds were popular in Denmark, Sweden and Switzerland.

In principle, the committee's attitude was unanimously in favour of the voluntary plan. The reasons were obvious. Such a plan:—

- (a) is far more in line with our philosophy of life;
- (b) preserves the freedom and independence of Catholic Hospitals;
- (c) is a guarantee against political influence;
- (d) gives greater security for professional interests;
- (e) is not subject to the criticism of a conflicting group;
- (f) leaves health responsibility within the family;
- (g) is a practical plan, for it has proven its soundness so far as hospitalization is concerned.

On the other hand, the committee was well aware of the facts:—

(a) the present health conditions are so bad, that the voluntary plan to be successful would require a people already sufficiently educated to avail themselves immediately of voluntary cooperation. The education of the Canadian people does not seem far advanced in this respect.

(b) Moreover, in spite of his desire to join a voluntary plan, the low wage-earner can scarcely afford a few dollars a year for health purposes.

(c) Hence, only part of the population can be included.

(d) Then, in periods of economic depression, the reserve fund of the voluntary plan is subject to depletion and hence requires higher rates of contributions.

(e) And last, European voluntary plans have nearly all failed to cope with national health problems of poor people.

In view of these drawbacks, the committee of the Catholic Hospital Council of Canada does not think that voluntary plans would be able to do much in the way of curative and preventive measures.

Is it therefore advisable to favour a compulsory state insurance?

The function of the state is twofold: first, it must protect the citizens and their rights, second, foster material, intellectual and moral prosperity. In order to obtain this purpose, the state is not to use arbitrary methods, but methods in conformity with the dignity of man. The state cannot use the pretext of common good to justify all means. The Soviet is looking for the common good of the Russian people, but their means are not acceptable to us; the fascists of Italy claim to foster the common good of the Italian people, but the state control system through corporatism is not acceptable to us. Hence the state in order to protect the dignity of man must avoid all kinds of state paternalism. Otherwise a scheme of social legislation might easily become *an instrument of social action with political purposes*. Therefore, in spite of the pressing needs, the state may promote a plan of health insurance as long as it respects the rights and freedom of individuals and of professional groups.

Therefore, very definite conditions are laid down by the Catholic Hospital Council of Canada for a Health Insurance Act.

(a) the freedom of choice for the insured regarding doctors, hospitals and nurses;

(b) the freedom of the physician to accept a patient;

(c) the freedom of the physician in the treatment;

(d) the safeguarding of the professional secret;

(e) the freedom of the doctor to enlist on the insurance-panel;

(f) the freedom of the hospitals in their administration;

(g) the independence of the professional groups;

(h) the autonomy of the medical, hospital, nursing association;

(i) no direct or indirect action on the part of the government to curtail the freedom of hospitals.

Provided these conditions are observed, the council agrees that a Health Insurance Act does not socialize medicine. On the contrary, it helps the poor to get medical services and the hospital and doctors to be better remunerated. The British, French and German laws have been very helpful for although the medical associations objected strongly to this idea in the beginning, they were finally won over completely.

But, in spite of all these conditions, the sisters are apprehensive of political intervention; they fear that the government will interfere with the hospitals, doctors and nurses, that conditions will be unfavourable to them, for the fact remains that they have not been considered on an equal footing with lay hospitals.

Although the majority of the sisters' hospitals do favour in principle the voluntary insurance plan, they agree, due to the present health conditions, to an insurance act only provided the conditions mentioned above are fulfilled.

If a compulsory plan was adopted, the question was discussed whether the plan should be federal or provincial.

Because of the British North America Act, art. 92, the recommendation of the Sirois report and the ethnical, cultural, geographic and regional differences of each province, the Catholic Hospital Council of Canada committee favoured a provincial scheme.

With a federal plan, the scheme could be:—

(a) either exclusively federal;

(b) or a compulsory Enabling Act;

(c) or a free Enabling Act like the Old Age.

There was strong opposition to an exclusively federal law. The Catholic Hospital Council of Canada respecting the British North America Act, and fearing political interference, bureaucratic control from Ottawa and administrative difficulties created by a federal bureau controlling local areas, immediately rejected the federal law.

It rejected also the compulsory Enabling Act which by inserting the text of the provincial law into the text of the federal Act, makes amendments of the former more difficult. The Catholic Hospital Council of Canada favours a free Enabling Act as long as federal and provincial legislation respects the clauses mentioned above.

Hence we might conclude that, in principle, the Catholic Hospital Council of Canada does not favour an exclusively federal state insurance, nor a compulsory Enabling Act, but accepts the free enabling legislation, provided the aforesaid conditions are fulfilled.

3. THE PROBLEM OF COVERAGE

According to the draft Health Insurance Act, one of the main principles upon which health insurance is founded is that it must cover the entire population. Since the fundamental purpose of the government is the improvement of the health of the people, it is thought that the proposed legislation must apply to everybody.

Another reason given by the report of the advisory committee is the following: if there is a limit in the model provincial bill, it would have to be a simple standard limitation. What is a suitable limit for New Brunswick or Saskatchewan might be totally inapplicable to Ontario or Quebec. Since there can be no standard and uniform limitation, it is proposed that the Dominion should adopt the basic assumption that all may benefit, leaving it to individual provinces to determine a limitation of coverage.

The Catholic Hospital Council of Canada Committee on Health Insurance is perfectly aware of the reasons given by the report. Nevertheless, the committee propose a limitation of coverage for three main reasons:—

- (a) the purpose of health insurance is primarily to cover the risk of sickness for low income groups;
- (b) the act must not and ought not interfere with the freedom of individuals and doctors. This is an important principle if we are to avoid state paternalism.

If clients have sufficient means to take care of themselves, as individuals or in groups, the state, by interfering, exceeds its functions. It assumes a responsibility which should be borne by the individual. Moreover, the state has no right to take away from the medical profession clients of greater means. Health insurance is a help not a cure for all. Otherwise, the same reasoning could hold for industry or schools. Efficiency is not the only criterion of sound government. It might be good for a short term investment but in the long run efficiency must be guided by the respect of individual liberties and rights.

- (c) The third argument derives from the European experiments. Almost all European laws limited the coverage. France, Germany, England limited their coverage to low income groups. France to the \$600 income for the farmer and to the \$720 income for the urban worker, increasing the coverage by \$80 for each child. England limited the coverage to the £250 wage-earner (\$1,217), Germany to the \$857 income.

After many years of experience, they have not covered the entire population. They were extremely suspicious and feared the socialization of medicine. An over-all coverage means that all individuals and all doctors and all hospitals are under the protection of the state. This is the fundamental reason why the Catholic Hospital Council of Canada is categorically opposed to the coverage of the entire population.

The Catholic Hospital Council of Canada does not consider it probable that a province would agree upon this limitation of coverage. Economically

speaking, no province can be expected to set a limit when a sister province will not set one. Industry and taxation will also prevent that province from imposing the limit. Hence we are faced with an economic motive, powerful enough to over-rule a principle of moral philosophy and common sense.

Hence, our committee proposes a limitation of coverage with a small margin of difference for the different provinces.

According to earnings of male and female employees, given by the Marsh report, a limit of about \$2,000 would seem reasonable. For those who have family responsibilities, an increase of coverage proportional to the number of children should be allowed.

EARNINGS OF MALE AND FEMALE EMPLOYEES IN CANADA, 1941

Earnings yearly	Male Heads of Families					
	Urban			Rural		
		Per cent	Cumulative		Per cent	Cumulative
Less than \$500.....	114,900	11.8	11.8	103,000	32.2	32.2
\$ 500- \$ 749.....	85,900	8.9	20.7	48,500	15.1	47.3
750- 999.....	123,200	12.7	33.4	40,000	12.4	59.7
1,000- 1,249.....	191,200	20.0	53.4	49,500	15.2	74.9
1,250- 1,499.....	114,900	12.1	65.5	25,000	7.6	82.5
1,500- 1,999.....	180,400	19.1	84.6	35,800	10.8	93.3
2,000- 2,499.....	75,200	8.0	92.6	12,900	3.9	97.2
2,500- 2,999.....	27,200	2.9	95.5	3,700	1.1	100.0
3,000 and over.....	44,800	4.5	100.0	6,000	1.7	100.0
Total.....	957,700			324,500		

Earnings yearly	Other Male Workers					
	Urban			Rural		
		Per cent	Cumulative		Per cent	Cumulative
Less than \$500.....	219,900	37.6	37.6	203,900	67.3	67.3
\$ 500- \$ 749.....	113,400	19.6	57.2	44,000	14.4	81.7
750- 999.....	90,300	15.7	72.9	22,700	7.4	89.1
1,000- 1,249.....	76,600	13.3	86.2	17,600	5.6	94.7
1,250- 1,499.....	30,800	5.5	91.7	6,200	2.0	96.7
1,500- 1,999.....	32,800	5.8	97.5	7,700	2.4	99.1
2,000- 2,499.....	9,000	1.6	99.1	1,900	0.7	99.7
2,500- 2,999.....	2,500	0.4	99.5	400	0.1	99.8
3,000 and over.....	2,800	0.5	100.0	500	0.2	100.0
Total.....	577,600			304,900		

Earnings yearly	Female Wage Earners					
	Urban			Rural		
		Per cent	Cumulative		Per cent	Cumulative
Less than \$500.....	279,800	50.0	50.0	107,200	73.4	73.4
\$ 500- \$ 749.....	132,600	24.1	74.1	24,300	16.2	89.6
750- 999.....	76,300	14.1	88.2	10,600	6.9	96.5
1,000- 1,249.....	36,200	6.7	94.9	3,600	2.3	98.8
1,250- 1,499.....	12,100	2.3	97.2	1,000	0.6	99.4
1,500- 1,999.....	11,200	2.1	99.3	800	0.5	99.9
2,000- 2,499.....	2,800	0.5	99.8	200	0.1	100.0
2,500- 2,999.....	700	0.1	99.9	.....	.....	.....
3,000 and over.....	500	0.1	100.0	.....	.....	.....
Total.....	552,200			147,700		

(from the Marsh Report.)

4. CONTRIBUTORY SYSTEM

The contributory system proposed by the draft is wholly accepted by the Catholic Hospital Council of Canada. It is more consistent with the dignity and independence of man. Benefit becomes then a right not a concession. Then with the contributions, the beneficiaries are kept in touch with the actual cost of the services they receive.

But these contributions should be graduated according to ability to pay. A flat rate of \$26 on \$866 income seems injurious to the \$1,000 income compared with the \$3,000. The poor again bears the brunt of the tax.

Fortunately, the draft is very generous for children. The scheme proposed gives complete coverage to the entire family and distributes the cost over the community as a whole.

These particular proposals, the Catholic Hospital Council of Canada hopes will be realized.

5. THE PROBLEM OF HEALTH CENTRES

One special problem of vital importance for Catholic Hospitals is the health centre. This might be considered a very insignificant part of the programme but it is of vital importance for our Hospitals.

The health centre is a system of organized hospitals and agencies linked together by contract and distributing not only medical but also social and economic services. Subsidies are necessary for their improvement. Perhaps the clearest example is the health centre in the Austria of pre-war days. A single hospital is chosen by the government as the health centre; other specialized hospitals are connected to the centre in such a way that special cases are directed towards the specialized hospitals; such agencies as those for maternal assistance, for care of the aged, the health department of unemployment insurance, children's aid, and a buying centre are all linked to the health centre.

This system greatly increases efficiency, lowers administrative costs and is much more efficient in following up cases.

Rumour has spread in Canada, especially in the western provinces, that such a health centre would be established in certain provinces.

Here again it is extremely important to insist on several points.

In a country of homogeneous groups and of homogeneous economic structure, such a health centre might be advisable. But in a country of a mixed economic and cultural structure, it might be a source of serious difficulties. An example will illustrate the point. Take for instance a western city of Manitoba or Saskatchewan where two major hospitals are located: one Catholic conducted by nuns, the other non-Catholic conducted by lay groups.

Who will determine the choice of hospital for the medical centre? Nuns having no political influence whatever will more than likely be disregarded.

Even if the hospital directed by the nuns were rated higher, it would still be put in second place. Hence insured people will be directed towards the health centre and so in practice, because of this pressure, will not be left free to choose their own hospital. Hence to avoid a conflict between denominational and non-denominational interests, we believe that it would be necessary to create Catholic health centres.

6. THE PROBLEM OF NURSING

The sisters direct 74 of the 175 nursing schools in Canada. Catholic nurses are 42 per cent of all Canadian nurses.

Their institutions differ widely from municipal institutions, particularly in their psychology of nursing. It is hoped that in the set-up of health insurance,

and in drafting the act which will govern its application, due consideration will be given to these institutions, in order to help the Sisterhoods to maintain their noble work, undisturbed in their devotedness to the sick and afflicted and with the same sacrificing spirit they have shown in the past.

Presuming that the foregoing statement has been given sympathetic consideration, the Nursing Service Division of the Catholic Hospital Council of Canada submits the following recommendations:—

It is recommended that the organization of health insurance will not interfere with the present set-up of nursing in sisters' hospitals, including those hospitals where sisters are employed as local administrators, supervisors of nursing or instructors of nurses.

In order to maintain good understanding with the government appointees and other groups interested in health insurance, also to make these appointees and other groups more familiar with the problems confronting Catholic hospitals, it is recommended that the Nursing Service Division of the Catholic Hospital Council of Canada be represented on all councils and boards of health insurance set-ups, federal, provincial and regional.

It is recommended that all boards engaging or directing nurses, in the set-up of health insurance, be organized in such a way as to insure that standards of nursing, policies governing nursing and conditions of employment in sisters' hospitals, be approved annually by the C.N.A. and the Nursing Service Division of the Catholic Hospital Council of Canada.

In order to allow a better understanding of the philosophy of sisters' hospitals and thereby to promote cooperation, it is recommended that, if available, sisters named by the Catholic Hospital Council of Canada be appointed supervisors of nursing in sisters' hospitals. These would act as associate directors to federal, provincial and regional directors of nursing service, in so far as sisters' hospitals are concerned, and with powers similar to those granted to the other nurse-directors in the health insurance set-up.

Although the nursing personnel in sisters' hospitals is as well qualified as in other hospitals, it is recommended that such qualifications be determined not only by the C.N.A. but also by the Nursing Service Division of Catholic Hospital Council of Canada.

It is recommended that sisters be given free choice and full control over the nursing personnel of their institutions, provided they conform to the standards laid down by the C.N.A. and by the Nursing Service Division of the Catholic Hospital Council of Canada.

It is recommended that standards of nursing service and policies governing conditions of employment and service for nurses in hospitals, in the set-up of Health Insurance, be approved by the C.N.A. and the Nursing Service Division of the Catholic Hospital Council of Canada.

CONCLUSION

It is most desirable that any measure of health insurance introduced should preserve the best in our system of hospital care and retain in our social set-up the institutions of private charity. Therefore the Catholic Hospital Council of Canada agrees to a free enabling legislation provided the specific conditions of page 13 of this brief are observed. It strongly emphasizes the necessity of having the direction of the plan strictly non-political through an independent commission answerable to the Lieutenant Governor in Council, either directly or through the Minister of Health.

It is highly desirable, considering the importance of sisters' hospitals all over the Dominion, that the nuns should be represented on the various committees of health insurance, federal and provincial.

In our opinion the health insurance fund should be supported by contributions from (a) the insured; (b) the employers; (c) the federal government; (d) the provincial government.

Because of the vital importance of the freedom of doctors, it is highly desirable to extend the health insurance act to the low income groups. For higher income groups, we suggest the promotion of voluntary schemes either under the form of groups plans or cooperatives.

It is also desirable that in post war construction plan for new hospitals, sisters should be consulted and protected.

All these summary conclusions follow from the philosophy of life of the Catholic hospitals.

Mr. Chairman, I might add as an appendix for the record an answer to a question suggested by the report of the Canadian Hospital Council given to this committee on April 9, 1943.

APPENDIX

What is the relation of the Catholic Hospital Council of Canada with the Canadian Hospital Council?

Does it approve of all the points of the brief presented?

The Canadian Hospital Council is a federation of provincial, inter provincial and regional hospital associations in Canada to whom belong the regional conferences of the C.H.C.C.

The Catholic Hospital Council of Canada is an association of Catholic Hospitals in order to promote their temporal and spiritual welfare. There is a great deal of cooperation and mutual understanding between the two organizations. With regard to purely technical matters, the C.H.C.C. and C.H.C. agree entirely. The difference starts with the philosophy and rationale of the hospitals. In fact, the C.H.C.C. agrees with most of Dr. Agnew's propositions.

It endorses the following points:

1. Voluntary hospitals should be utilized.
2. Hospitalization should be through public hospitals.
3. Hospital benefits should be reasonably complete.
4. Facilities should be made available for all types of patients.
5. Hospitalization of indigents should be provided for under the plan.

It might be well to inform the Committee on Social Security that as discussions are going along, some specialists in the field have changed their mind on the subject of Health Insurance. From Alberta, Manitoba, Nova Scotia, I am informed that eminent doctors, superintendents of great hospitals who, two years ago, were in favour of health insurance, are now extremely suspicious of the outcome. The bishops of Western Canada strongly urge the Catholic Hospitals to protect their freedom and independence.

Hence, the federal government must steer a course between two obligations: that of respecting the autonomy of the provinces and also that of forbidding certain provinces from infringing upon the character and philosophy of our Catholic Institutions.

Hence it might be necessary to insert in the federal bill certain restrictions preventing provinces from acting in an arbitrary way towards our Catholic Institutions.

In order to avoid misunderstanding and difficulties, it might be advisable to lay down certain fundamental principles on which every province of Canada will agree leaving to the provinces the manner in which the law is to be applied.

We know that Dr. Heagerty's committee has proceeded with the greatest prudence and carefulness. The committee has shown in its tremendous work a real scientific spirit, a sense of objectivity and reality in consulting different

groups. Unfortunately, the direction of such a scheme will be subject to political criticism and the principles advocated might be sacrificed. Hence many who favour this idea are apprehensive lest such a useful social instrument become an instrument of political action.

6. Dependents of the insured should be included.
7. Remuneration of hospitals should be adequate.
8. Basis of remuneration should be fair to all parties concerned.
9. Hospitals should retain the right to determine their own staffing privileges.
10. Insured persons should have the privilege of taking higher priced accommodation by paying the difference in charges.
11. Direction of the plan should be strictly non-political.
12. There should be hospital representation on the Commission or Advisory Council.

13. The Health Insurance fund should be a contributory one.

The C.H.C.C. also endorses the general recommendations about preventive medicine, research, teaching hospitals, divulgence of clinical data. It recommends also voluntary hospital and medical care for those above the income level.

However, the C.H.C.C. insists:—

(a) on having the plan on a provincial basis with federal financial subsidies. The Council does not accept a common nationwide plan infringing upon the autonomy of the provinces. There is perhaps one case: the federal might influence the provincial legislation when a provincial act threatens the independence and the autonomy of denominational institutions;

(b) the C.H.C.C. insists on having the plan for low income groups;

(c) the C.H.C.C. insists on protecting the sisters' hospitals particularly on two points: the "medical centres" and "post-war construction planning".

The Catholic Hospital Council of Canada wishes to express again its gratitude for such an opportunity to appear before this committee and wishes also to record its desire and willingness to cooperate in the framing up of any plan of health care that will be of lasting benefit to the sick and will promote better health for our Dominion of Canada.

In concluding, Mr. Chairman, allow me to say that the Catholic Hospital Council of Canada is very grateful to you as well as to the Hon. Ian Mackenzie for having made it possible for them to appear before this committee to express their views and their friendly criticism which may be necessary to enlighten the members of the committee.

Again I thank you, and you may rest assured of the entire collaboration of the Catholic Hospital Council of Canada.

By Mr. Howden:

Q. I should like to refer to the witness' remarks on page 13: "But, in spite of all these conditions, the sisters are apprehensive of political intervention; they fear that the government will interfere with the hospitals . . ."; would the witness give us a little further amplification in that regard? I fail to see in our bill anything which at all suggests interference of any kind with any hospital, either Catholic or private in nature.—A. Mr. Chairman, I wish to answer by giving a distinction between the terms and the application of the law. In fact you might have a bill which might be inoffensive but in its application we have no guarantee that it will be followed. You know, probably, by your personal experience, Mr. Chairman, that theory is always easy and practice is a complicated problem, due to political pressure. Now, it is rather hard for me to quote facts, but I might say that in several instances sisters

have not been treated on an equal footing with others. Mr. Chairman, I believe the draft is acceptable provided certain modifications are made but, nevertheless, we are afraid because we are not sure of the men who will be charged with the duty of administering the law.

Q. I would like to say that although I am a Protestant I have been on the executive of a large western Catholic hospital for a good many years. I do not think that hospital has at any time received unfair treatment or that there has been any discrimination whatever with regard to the treatment of the St. Boniface hospital in the province of Manitoba as compared with the Winnipeg General Hospital or any other hospital in the province. I have never heard of any complaint of the sisters so far.

By Mr. Donnelly:

Q. May I refer to the bottom of page 13 where the witness says: "...for the fact remains that they have not been considered on an equal footing with lay hospitals." I would like to know what ground there is for that statement?

—A. Well, Mr. Chairman, I dislike very much giving names or particulars but I may say that with regard to nurses, for instance, sometimes the sisters have not been given the opportunity of having the representation they should like to have. That is not due to personal animosity, not at all. Dr. Howden of Manitoba might have a very good case, but there are other hospitals and we must be extremely careful to prevent difficulties before we get the law set up. It is a matter of prudence.

Mr. MCGREGOR: I should like to ask the witness where in western Canada he will find political interference with hospitals at the present time?

The WITNESS: I cannot answer that question.

Mr. SHAW: The witness laid stress on the necessity of having the scheme apply to those of low income brackets, yet later on he also indicated that they would insist upon additional services being available for those who could pay for such additional services. My feeling is that if a scheme such as this applies to those of extremely low income brackets it is going to be virtually impossible to finance a scheme of this kind, and it is likely to be an absolute failure. I cannot see what objection you would have to having this scheme apply to all our people provided additional or special services and accommodation were made available to those who are able to pay for such additional accommodation or services. Could you elaborate upon your reason?

The WITNESS: Mr. Chairman, this is a very strong objection. Most people think that in order to be able to finance a plan of health insurance it is necessary to apply it to all people in order to get a sufficient amount of money to finance such a plan. Am I correct?

Mr. SHAW: I think that is correct, generally.

The WITNESS: I must make a distinction here. In a matter such as health insurance there are two problems: the first is a problem of principle and the second is a problem of application. Now, if you consider the problem of principle you will find that health insurance is, by definition, a help to the individual. Health insurance, by definition, is a means whereby the state helps the individual to cover the risk which he cannot cover himself—the risk of health or unemployment or old age. If I include all individuals in this scheme that means that I am including not only those who are incapable of covering the risk, but also those who are capable of covering it, therefore bringing all the population under the protection of the state. In health insurance, it is extremely important to avoid state paternalism; we must respect the freedom of the individual and, if doctors have clients who are capable of paying, the doctors should be able to keep those clients. You may say: what about the finances? In order to finance the whole scheme of health insurance

could you not call on the reserve fund of the dominion, on taxes? You may object, "We do not care about the principle; we care about the finances." I say that we could not agree to that in our philosophy. First, before the law we have to outline certain principles and then apply the law in order to save those principles. Therefore, I say that in order to save the freedom of doctors and individuals let us help the low income group first, and then, if necessary, let us try to take in the higher income groups by voluntary plans or by group plans. My main idea is that the principle comes first and that the application comes second; and you have to modify your financial system or your economic calculations in such a way as to save the principle.

Mr. SHAW: I understand that if we had complete coverage we would not prevent the individual from paying additional for certain services, if he desires to do so, or of paying for additional accommodation. I do not think you are affecting the principle; you are not saying to the individual, "you must subscribe to certain conditions completely", but we are leaving freedom to go beyond the mere point of contribution to assist in the financing, which is going to be one of the great problems in connection with our scheme. I feel that we are not interfering with that essential principle to which you have alluded.

Mr. LALONDE: Mr. Chairman, reference has been made within the last few minutes to political interference in the application of the law. Really, I do not know what has been happening in the other provinces but I want to emphasize this point, that our health insurance plan is not totally exempt from political interference or the prospect of political interference, and if it is not so I am not in favour of health insurance at all. Therefore, I agree with the witness when he says that political interference must be very carefully considered as regards the prospective bill. I might illustrate my thought with a concrete case in my own province. I am not speaking as a Catholic—not at all—I am speaking as a member of this committee which is giving careful study to this question. In 1936 the provincial government of the province of Quebec was put into the hands of Mr. Duplessis, and what happened? In my own town we have a small hospital which falls under provincial jurisdiction and political interference resulted in impairing the work of the hospital. In the prospective bill I understand that the provincial authorities would have the right to appoint committees, commissions and so on. Mr. Chairman, if politics enters into the consideration when these appointments are made then I say I am not in favour of the bill. This concrete fact—I do not mention any names—but this concrete fact leads me to believe that the strong plea of the witness against political interference should be maintained and approved by the members of this committee. For instance, I had at one time the provincial patronage for the county of Labelle and I had in my hand a letter from the then provincial secretary for a grant to the hospital of my town, but immediately after a change in the government that was refused just on political grounds, and this grant was refused to the hospital. So I am in favour of the suggestion made by the witness, not only on behalf of Catholic hospitals, but as a general principle, that political interference must be absolutely stricken out of the scheme. This is my opinion, Mr. Chairman, and I do hope that it is shared by the great majority of the committee.

Mr. HOWDEN: I am in entire agreement with the last speaker; I agree that there should be no political interference and that there should be no discrimination as between lay hospitals and Catholic hospitals; but I would like a more definite and concrete suggestion as to just what sort of political interference may obtain. Is it in the way of directing patients away from certain hospitals? In what way could we have political interference? I would like to be enlightened upon this matter. I think we should get right down to

brass tacks because this is a very important matter. There should be no political interference, no discrimination; but let us get down to it now and find out what form this discrimination takes.

MR. LOCKHART: Mr. Chairman, as one who has had some contact with hospitals in Ontario and as one who is very sympathetic to a dominion-wide scheme it would appear to me as though there might be a condition existing in certain isolated parts of Canada whereby some prejudicial influence had been brought to bear in individual cases. Now, speaking from some experience, and with some knowledge of treating the sick in many parts of Canada, I do not think we should allow our minds to run into parochial channels, and I would say that if conditions such as have been inferred do exist then it seems to me that some housecleaning ought to be done in that particular area, but that the condition should not be made to apply to the dominion as a whole. I suggest that this housecleaning should take place wherever these isolated cases arise, but make sure that they have to follow the general plan that is being laid before this committee for a dominion-wide organization. I suggest, Mr. Chairman, that we are probably running down a blind alley when we deal with local situations rather than with the broad success which we hope this plan will effect.

THE WITNESS: Mr. Chairman, my specialty is not politics. I have to leave the problem of political interference to our French-Canadian representatives here, Mr. Lalonde or Mr. Blanchette. In virtue of my vocation I have to keep away from politics, but I was asked for an example and I will try to illustrate by example, getting down to brass tacks, to use Dr. Howden's expression. With regard to the construction of a new hospital, who will decide? Who will assign the zone of the new hospital? Who will decide whether the hospital will be conducted by a religious or a lay group? That might give you a hint of what I mean by political intervention.

MR. MACINNIS: Mr. Chairman, never having been a distributor of political patronage I have not had any of the difficulties experienced by my friend here, but I think we are creating difficulties that really do not exist or, if they do exist, cannot be got over just by ignoring them. Because of the economic inequalities within our country, the government has been compelled to take cognizance of the health of the people, and the people's health cannot be safeguarded without government interference. Government interference means political interference; but I think that we will find that the objections to political interference or the fears of political interference are due to certain institutions wanting state assistance without state supervision, and that cannot be. Now, in my province of British Columbia—I am not particularly enamoured of the government—they are operating a mental institution, and I find that despite what political interference there may be there the staff of that institution has a high social concept of its duty to the public; and I believe that the way to overcome those political differences is to increase our social philosophy or to improve our social philosophy rather than to be putting up barriers against contacts in matters that the state must of necessity concern itself in.

MR. JOHNSTON: I should like to say a word with regard to the principle of health. I take it from what the witness has said, and I think it is generally true, that the whole principle of social security is based upon health and the belief that we must have a healthier nation, and that is the basis of this legislation. I cannot agree that we should have a ceiling on incomes of \$2,000, such as was suggested by the witness. That would lead me to believe that those in the income group of over \$2,000 were in a better health condition than those with an income under \$2,000, and I do not think that is borne out in fact. I am not going to argue that point. On page 8 a specific reference was made, and I would like to refer to

it now. The witness said: "The logical way to cope with this problem is to complete the deficiency in wages by social insurance. By social insurance, the workers pool certain resources in order to face certain risks of life like unemployment, old age and sickness. We might, in theory, give to the worker a wage rate which would cover these risks but unfortunately economic and industrial conditions do not allow such a wage." Now, I suggest that if that were the case the economic problem would be the one we would have to solve, and not the one we are facing at the moment. Then the witness goes on: "Hence the necessity to protect the worker through social security. This necessity has its fundamental basis in justice and charity." Now, I object to that last sentence, I object strenuously; I do not believe that there should be any shadow of charity in this legislation. That is why I strongly object to having a ceiling on income for the purpose of social benefits under this Act. I think everybody should be allowed the same privileges, and that they should be subjected to the same obligations in getting them; because I do not think that we should give our people the feeling, especially those in the lower-income brackets, that they are forced to accept charity.

Hon. Mr. MACKENZIE: I think possibly the word "charity" is used in a different sense here. I take it to be used in the way of kindliness, and not in the way of a handout.

Some Hon. MEMBERS: Yes.

Mr. JOHNSTON: It means the same thing, Mr. Minister. I think that when people are subjected to that beneficent handout, it is practically the same thing; and the people generally do not want to accept that. I personally would take very strong objection to that. I think this thing should be put on such a basis that everybody will be treated alike and that there will be no class distinctions. I would strongly object to having a ceiling put on the income, and then those who are privileged to have special services; I have no objection if they wish to get them, but the whole thing should not be based on that.

Mr. GERSHAW: I think this has been a very clear submission. But there is one point on which I should like to ask the witness to give us some further details if he has given the point consideration. At the bottom of page 19 it says:

"But these contributions should be graduated according to ability to pay. A flat rate of \$26 on \$866 income seems injurious to the \$1,000 income compared with the \$3,000. The poor again bears the brunt of the tax." How would he suggest graduating the contributions? Would he have them linked up with the income tax, would he have a very low flat rate for everybody, or would he try to inquire into the financial ability to pay of every householder?

The WITNESS: Mr. Chairman, I will answer the two questions, if I may—the first on justice and charity and the second with regard to graduation of the tax. First, with regard to justice and charity; as the Honourable Minister just mentioned a moment ago, I think the word "charity" might lead you into error; because, in justice, I would say there are two notes or two characteristics. You have one kind of justice by which you give to an individual what is due to him. But there is another type of justice which requires a flavour of charity, and which I hope every government man has in his heart. When he has a social obligation to fulfil and when he sees that it is necessary to give to the people certain help, does he give him that support in virtue of justice only or in virtue of justice which has a colour of charity?

Mr. JOHNSTON: That is charity of the heart; the other is charity in finance. They are different things.

Hon. Mr. MACKENZIE: I thought there was no charity in finance, Mr. Johnston!

The WITNESS: The second difficulty mentioned by the representative is about the graduation of the tax. Unfortunately, I have not the actuarial data from which to give you a definite answer to the problem. But I would say that there would be a possibility of setting up a proportional tax for each kind of individual income. Of course, in the German plan you have a proportional clause depending on the wage; in our Unemployment Insurance Act you also have a proportional clause depending on the wage. Hence the graduation of the tax is not impossible—

By Mr. Howden:

Q. May I ask the Rev. Father about something that appears on page 16:—

The Act must not and ought not to interfere with the freedom of individuals and doctors. This is an important principle if we are to avoid State paternalism.

I take it that in that clause he and those for whom he speaks are objecting to the general coverage of the bill. I was just going to propose this question. Assuming that there is to be general coverage, would he consider the great unfairness to those well-to-do people who might stay outside the Act, who might employ their own doctor and pay for their services if they preferred to do so rather than accept the services provided by the bill?—A. To be consistent with the brief I have just submitted, I would say, first, that an Act including all individuals would be an Act covering the activities of doctors, hospitals and clients. Secondly, the client might be free to get out of the Act and do what he pleases, but nevertheless there would be a tendency for the government to favour state paternalism in including all the individuals. May I illustrate? Suppose you are covering the higher income group, the doctor of the higher income group is linked also with the government; his services are dependent on the insurance Act. That is why I would prefer, as a principle, to have the government keep away as much as it can. I would advocate that as a principle. As a representative of my committee, I think that the state must come in only when individuals or groups cannot do the job. If individuals or groups cannot do the job, let the state come in. That is the general principle: No state paternalism.

By Mr. Lalonde:

Q. Intervention undue—undue intervention?

By Mr. Howden:

Q. Father, may I take it that you are, shall I say, against taxing the well-to-do people so as to share the burden of services supplied to the less well-to-do?—A. No. I certainly am not; because we will have to tax the well-to-do in order to do the financing of this health plan. But the manner in which you will tax the well-to-do will be different, and that is extremely important. That is why I am getting back to the first answer I gave. When you have health legislation of that type, first get the principles settled because these will guide you in the clauses of the law. Suppose you tax the low-income groups by a little tax. You will not be able to pay the cost. Then tax the higher-income groups by the usual income tax, and take a share of the income tax to cover the expenditure or cost of the health insurance.

Q. Suppose the whole thing were to boil down to income tax.—A. Then you would bring in the New Zealand plan, practically, by which you have a general social security fund covering all the risks of the individuals. But here again, this is a manifestation of state paternalism. First of all, you must not forget that New Zealand is not a state like Canada because New Zealand has no provinces like we have. Consequently a general tax means, indirectly state protection.

I would be strongly opposed to a general tax because it would be a form of state charity, and that is the main thing to be avoided; with social insurance the individual puts money aside to cover a definite risk. Otherwise you are bound to live "au crochet du gouvernement."

MR. MACINNIS: I want to take up this point where it is contended that if we had a tax for health insurance it would be charity. Across Canada we have public schools which are financed from a general tax. Surely no one thinks that the public school is a charity provided for the poorer people. Is it not based upon the conception that an ignorant person is a menace to society and that a person with education is a valuable asset to society, and consequently society educates the individual. Will not our health insurance be based on the same premise, that a sick man is a menace to society and that a healthy man, a healthy woman or a healthy child is an asset to society? Then society taxes itself or in other words allocates its income so as to take care of the sick. Let us remember this. The speaker gives on page 18, I think it is, the wages of the workers in Canada. If there is an income pool out of which this health insurance Act can be financed, that pool has been made available by the unpaid labour of these low-paid people, and consequently they are not getting half of what is coming to them. If you go to divide them up into rich and poor classes, you will find, possibly, that they will decide that they are not satisfied with that sort of thing, and they will take it all.

MR. SHAW: I have just one observation. My contention is this: If it is proper for the government to impose itself upon the individual of low income, it is equally proper for the government to impose itself upon the person of high income. Most of our people fall within the low-income brackets; and in the final analysis that might be attributable to economic policy which is traceable to government policy. I say definitely that if it is proper to impose conditions upon the individual of low income, it is equally proper to impose the same conditions upon the person of high income, especially under conditions such as we have relative to the health insurance proposal.

THE WITNESS: Mr. Chairman, if I understand the speakers, their argument is based on the necessity of the state to substitute itself to all individuals. We must not forget the two functions of government: First, to protect the rights of individuals—and this is important; second, to foster intellectual, physical and moral prosperity. Therefore, if I assume as a hypothesis that government must do everything, the questions proposed are perfectly justified. But if the government must do a thing which an individual cannot do, this is an entirely different proposition; because then the government is not a substitute but a help. And to my mind the government must not be a substitute for men but a help, as otherwise you might favour unsound political theories. I might mention to you the German health insurance Act. According to Professor Brüning, "health insurance under any government might be a good thing provided the government is safe". But now, everyone knows what is happening in Nazi Germany. The Nazis took over their health insurance. They are taking over all their social security as a means of control. That is why I say state paternalism instead of being an instrument of social action, is an instrument of social action with political purposes.

By Mr. Shaw:

Q. We are always subject to that danger in any field of activity?—A. Yes. But, Mr. Chairman, if we can avoid it, let us do it.

MR. MACINNIS: I should like to ask the speaker a question. He said one of the functions of government was to protect the rights of the individual. Consider-

ing the number of low-paid people in Canada, the number who cannot provide for themselves the comforts and decencies of life, does he not think that the government has failed to protect those rights or to exercise one of its functions?

Mr. LALONDE: You should ask that question of the minister.

The WITNESS: I would prefer to leave the question to Hon. Mr. Mackenzie.

Hon. Mr. MACKENZIE: I will submit it to the House of Commons.

Mr. JOHNSTON: May I make one observation there on what the witness said a moment ago, that it was the duty of the state to protect the rights of the individual, with which I agree. I think from there on his main concern, as far as this legislation is concerned, was that it is the duty of the state to protect those in the low-income brackets because they were not able to take care of themselves, that it should interfere with their rights as little as possible but yet it would have to interfere with them until such time as their income condition was such that they could take care of themselves. I think, myself, that the problem is not so much one of social security as it is one of economic security; and until such time as the governments of the peoples definitely deal with the economic condition whereby they are going to raise these people of low-income brackets to higher-income brackets, then I think everybody else should be treated accordingly. But as I interpret what the witness has said, it is an economic problem, and the main concern should be to provide for the economic security of these individuals. They are two different problems.

The WITNESS: The question proposed is extremely important, because you are taking two problems—the short-run problem and the long-run problem. I think that the problem of social legislation is primarily a short-run problem. I think that if a government were to put into force a social security act without taking into account the matter of prices, the question of production, the question of agriculture, the distribution of resources, it would be a tremendous mistake. The low-income group, instead of diminishing would always increase. Therefore I would say this. In social security or in health insurance, let the government take care of the one side of the picture, the long-run view—which would be the matter of prices or the matter of raising the standard of living—and the short-run view, with social legislation. We cannot wait years and years to increase the economic standard of living and have the individuals dying or having their health in bad conditions. Therefore I would say that both policies go together pretty well, the short- and the long-run.

By Mr. Fulford:

Q. We do not seem to be getting far on the discussion of these economic principles. I want to ask a question along entirely different lines. On page 24 we find:—

Although the nursing personnel in sisters' hospitals is as well qualified as in other hospitals, it is recommended that such qualifications be determined not only by the C.N.A. but also by the Nursing Service Division of Catholic Hospital Council of Canada.

It is recommended that sisters be given free choice and full control over the nursing personnel of their institutions, provided they conform to the standards laid down by the C.N.A. and by the Nursing Service Division of the Catholic Hospital Council of Canada.

Is that not a general practice in Catholic hospitals? I do not think there is any suggestion in the proposed act that there would be any interference; certainly I do not think there is any intention in the act to force nursing personnel on any Catholic hospital which is not acceptable to them.—A. Well, Mr. Chairman, if Mother Allaire were here she could give you examples of certain hospitals where

certain nurses have encroached upon this problem with regard to the sisters. That is why, in order to protect them, we were advised to have nurses on these boards.

The DEPUTY CHAIRMAN: Are there any further questions?

By Mr. Howden:

Q. There is just one other matter that challenged my attention as we were going over the notes. That was on page 21 where the Rev. Father was discussing the distribution of health centre hospitals. In the second paragraph from the bottom of the page he says:—

Who will determine the choice of hospital for the medical centre?
Nuns having no political influence whatever will more than likely be disregarded.

The thought occurred to me while we were reading over those lines that, to the best of my knowledge, in the west so far we have been glad to take advantage of any hospitals that the sisters have offered to build in outlying districts for service of these health centres. I was wondering if it had been the experience of the Catholic Hospital Association that they had been subjected to discrimination in the matter of these health centre hospitals?—A. Mr. Chairman, I could not give a definite answer to Mr. Howden's question. I am told that the superintendents of two hospitals changed their minds completely with regard to the problem of health insurance. They are afraid of the outcome. If the provincial government is not favourable to Catholic hospitals, you can readily understand the difficulty without the protection of our hospitals. It might not be the case for Manitoba.

Q. They are very favourable there.—A. I know it is the case in Saskatchewan. In Alberta the superintendents themselves are afraid. That means that we have to be extremely careful in that matter, if such authorities change their mind.

The DEPUTY CHAIRMAN: Are there any further questions? If not, I wish to thank Father Bouvier for the very excellent presentation which he gave us this morning. I do not think that the Catholic Hospital Council made any mistake in delegating him to come here and give us the brief which he did. If it is the wish of the committee, we will now adjourn until next Tuesday, when we shall have a French organization, La Confederation des travailleurs Catholiques du Canada. The second group which is to appear that day is the one representing the osteopaths. That will be on Tuesday next at 11.00 o'clock.

Mr. FAUTEUX: Before we adjourn, I should like to make one observation. I do not think that we can have a complete picture of health insurance plan without studying the question of slums which are responsible for sickness, as you know, such as tuberculosis. I should like to know if it is the intention of this committee to hear any experts on this matter.

Dr. HEAGERTY: Mr. Chairman and members of the committee, a number of studies have been made on slum conditions in Canada and in other countries. I prepared for Hon. Mr. Mackenzie a memorandum upon the subject and the relationship of death rates in slum areas, under poor housing conditions, chiefly in England. That would be available for the committee. If it is the desire of the committee to have experts come here and deal with the subject, there would not be any objection. But I should be glad to place before the committee any material that the advisory committee has on hand in that respect.

Mr. FAUTEUX: If I urge that, Mr. Chairman, it is because a few days ago I received a letter from a broker. As you know, I represent the constituency of St. Mary in Montreal. Part of my constituency is a very old district of the city and, I may say, is very poor. A few weeks ago, just after the victory loan campaign, I received a letter from a broker who did a lot of work in my constituency during that campaign. He wrote me a letter and told me how pitiful

it was to see the condition of certain houses in my constituency, how many people living there were sick and so on. So I wrote to the parish priest telling him that I was very anxious to have his opinion on this matter, as to whether what the broker had told me was true. He wrote me a very interesting letter, drawing my attention to the fact that although in Ottawa we were doing a lot of work, and seemed to be very serious in working on a social insurance plan, we would not succeed in doing much as far as social security is concerned if we left out of consideration such conditions as slums. As far as I am concerned, I would appreciate it very much—not for myself but for these poor people—if something could be done along that line.

Hon. Mr. MACMILLAN: Mr. Chairman, I discussed this question with Dr. Fauteux because I know he is very deeply interested in it. I would suggest that the committee receive a memorandum from Dr. Heagerty, have it placed on the record and study it. Then if there is any other information desired or required, we could call some expert witnesses in consultation, if that is satisfactory to the committee.

Mr. LALONDE: This question of slums, Mr. Chairman, is also a question that interests the rural part of Canada. In my riding also, while we do not face the same problem exactly, there are also a number of people living in very poor quarters. So I should like to have this brief submitted by Dr. Heagerty cover also the question of poor lodgings in rural districts. I know very well that settlers in Labelle and all the rural counties would be very glad to know that this committee is studying the question of improving their conditions.

The DEPUTY CHAIRMAN: We will have that matter considered.

Mr. JOHNSTON: Before we adjourn, may I say that, inasmuch as I imagine we are now getting along to the time when nearly all the submissions have been made to the committee, I was wondering if Premier Garson of Manitoba could be invited to appear before this committee and give us the submission he gave before the reconstruction committee. I would recommend that he be invited to appear before the committee and present his submission.

Mr. ADAMSON: I want to support the honourable members from Montreal and Labelle. I represent a Toronto constituency where identically the same conditions exist with regard to slums. Slum conditions have undoubtedly seriously affected the health of the people in my constituency, and I think one of the essential things this committee should take up is rehousing and rehabilitation of slum conditions. I would suggest Mr. Chairman, that we might ask some of the housing experts and the slum clearance experts, who do exist in Canada—there is available a great deal of extremely valuable information—to appear here. I might suggest that we have a joint meeting of the reconstruction committee and this committee to take up this matter of slum clearance.

The DEPUTY CHAIRMAN: I understand that the question of hearing more witnesses will be considered. In the meantime might I ask Mr. Johnston if he would find this suggestion acceptable—to have the brief of the premier that he has just spoken of included in the record?

Mr. JOHNSTON: The only objection I would have to that course is that I think it would lose its effect in that way. Take the submission that was made here to-day. Had the witness just submitted it and put it on the record, I do not think we would have got nearly as much benefit out of it as we did get by hearing him present it himself and by questioning him. I think he has cleared up a lot of points and I think it would be greatly desirable to have Premier Garson here in person to make his presentation.

The DEPUTY CHAIRMAN: That will be considered.

We will now adjourn until next Tuesday.

The committee adjourned at 12.35 p.m. to meet again on Tuesday, June 15, at 11 o'clock a.m.

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Canada, Social Security
Committee on, 1943

SESSION 1943

HOUSE OF COMMONS

SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 21

TUESDAY, JUNE 15, 1943

WITNESSES:

Dr. George A. DeJardine, President, Canadian Osteopathic Association;
Dr. Allan A. Eggleston, Montreal, P.Q.
Dr. Eldon S. Detwiler, London, Ont.
Dr. St. Clair Parsons, Ottawa, Ont.
Dr. J. R. G. McVity, Toronto, Ont.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

TUESDAY, June 15th, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs., Blanchette, Bourget, Breithaupt, Bruce, Casselman (*Mrs.*) (*Edmonton East*), Claxton, Cleaver, Côté, Diefenbaker, Fulford, Gershaw, Gregory, Hatfield, Howden, Hurtubise, Kinley, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, McIlraith, Mayhew, Shaw, Warren, and Wood.—29.

The Chairman read an invitation from the Voluntary Health Committee of the House of Commons and the Senate to the Social Security Committee to join them in a meeting on Friday, June 18th, at two o'clock, p.m. in Room 268, House of Commons. The Chairman stated that as the Voluntary Health Committee was not an official committee it would rest with the members individually if they wished to attend.

The Chairman read a telegram from the Confederation of Catholic Workers stating that their delegation which was to have been present to-day were unable to come, but were sending a brief which they wished to have included in the evidence. It was agreed that this brief, when received, would be printed in the evidence.

Dr. George A. DeJardine, President, Canadian Osteopathic Association, was called. He introduced the following delegates of that organization:—

Dr. Allan A. Eggleston, Montreal, P.Q.;

Dr. Eldon S. Detwiler, London, Ont.;

Dr. St. Clair Parsons, Ottawa, Ont.;

Dr. J. R. G. McVity, Toronto, Ont.

Dr. DeJardine presented a brief, and he, with the other delegates was examined and retired.

The Chairman thanked the witnesses and the Committee adjourned at 1.15 p.m. to meet again Wednesday, June 16th, at 12.00 o'clock noon.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 15, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Ladies and gentlemen, I have been asked to make the following announcement. At the last meeting of the volunteer health committee of the House of Commons and the Senate a resolution was passed to the effect that members of the special committee on social security be invited to attend the volunteer health committee. The next meeting of that committee will be on Friday, in room 268 at 2 p.m. The social security committee is a special committee of the House of Commons, an official committee, the volunteer health committee is an unofficial committee; therefore, while we appreciate very deeply the invitation, it is a matter for individual members and not for the social security committee as a body to attend in their official capacity. Any individual member of this committee will be welcomed at room 268 at 2 p.m. on Friday.

Now, I have a telegram from the Catholic Workers' Organization of the province of Quebec: "Brief on health insurance mailed to you to-day by Confederation of Catholic Workers of Canada. May we cancel delegation schedule for June 15. Mr. Charpentier and I are tied up and it is impossible to appear before the committee."

The brief has not arrived; but with your permission, when it does arrive, it will be placed on the record and distributed to the committee.

This morning we are to hear the Canadian Osteopathic Association. The brief will be presented by Dr. DeJardine of Toronto.

Dr. G. A. DeJARDINE, *called*.

The WITNESS: Mr. Chairman, Mr. Minister, and members of the Special Committee on Social Security, may I first present to you my colleagues representing the Canadian Osteopathic Association. This committee represents osteopaths throughout Canada, which is a point I would like to make very clear; this has nothing whatever to do with, for instance, the Board of Regents of Ontario. We are speaking for the osteopathic physicians from British Columbia to the maritime provinces, and we have authority to do so from the different associations. I would like to make that clear right from the start. Now, may I introduce to you our delegates: Dr. E. S. Detwiler, of London, Ontario, who was here a little while ago representing the Board of Regents of Ontario of which board he is chairman; Dr. J. R. G. McVity of Toronto, who is treasurer of the Canadian Osteopathic Association; Dr. St. Clair Parsons of Ottawa and Dr. Allan A. Eggleston of Montreal, who is vice-president of the Quebec Osteopathic Association.

In opening, I should like to express my appreciation for the invitation which has been accorded to us to present osteopathy before this committee. We deem it a great honour to be here and to present our profession before the members of the House of Commons. I think it is a great privilege. We have never had a similar privilege before and we hope we will be able to clear up in your minds a lot of possibly wrong ideas that you may have privately regarding osteopathy.

Of course, in Canada we are a minority. We must take second place to the medical profession. The medical profession is doing a magnificent work, and, I

am sure, is doing the utmost in their power for the health of the people of Canada and for public health generally. However, while we take second place to them in numbers we wish to make the point that we believe we are also as sincere in our endeavours on behalf of public health as they are. We may not, of course, have accomplished as much, but we are certainly doing the best we can, and we would like to co-operate with you in solving this health insurance problem. Health is the birthright of every Canadian, and whether he gets that health from one school of medicine or another school of medicine we feel that at least he should be entitled to it. If he cannot get it from one school he is entitled to get it from another. I may not have put that exactly right, because health is not exactly a commodity that is within the power of the different schools to give; they can guide the people in the direction of how to obtain health but, after all, health comes from one source, nature, with the healing powers or the repairing powers of the human mechanism. When that mechanism is damaged or below par—these healing powers are a biological process—we cannot scientifically produce one atom of life and yet when there is disease there is destruction of life of the individual tiny cells in the body. Those cells have got to be replaced. That is a biological process. All we can do is to try to see that conditions are right in accordance with the laws of nature, so that nature can produce that health within the human mechanism.

Unfortunately, as regards osteopathy, perhaps because of our small numbers, it has been surrounded by what we might term more or less a smoke screen of error or, perhaps, it might be better described as a miasma of falsehood, not necessarily intentional; but all the time we are faced with statements that we hear about osteopaths which have not a particle of truth in them. So, we appreciate this opportunity to be here in order that we might be able in some measure to remove some of these misconceptions.

Now, to the south of us there is a great nation, a nation of 140,000,000, and there they are also working on this problem of health insurance, and they are very seriously endeavouring to give to their public the very best they can as far as health is concerned. We have a population here of approximately 10,000,000 or 11,000,000, and you are attempting to solve a very difficult problem, and you have done an enormous amount of work in this direction. I am sure you will concede that the members in the United States who are in a similar position with yourselves are just as sincere in their efforts to promote public health in the United States. Their responsibilities for 140,000,000 people are as great as yours for our 10,000,000 or 11,000,000.

First, I should like to refer to a public law No. 831 that was passed by the 17th Congress of the United States. This is a law for the District of Columbia, where the capital is situated. That law states that the degrees of doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges as under government regulations. That law, gentlemen, I suggest might almost be referred to as enabling legislation to this extent, that it is a pattern and a model, perhaps, set by the government of the United States on which to model legislation in the various states. Now, in reference to this, according to the Act that has been proposed, I have referred to this law which says that these two schools of medicine shall be accorded the same rights and privileges. According to Dr. Heagerty in some questioning that came out a few days ago, he, in effect, practically says—and this, of course, is the Act, not Dr. Heagerty personally—that the medical profession shall have all the rights and privileges in Canada, and we might refer also there to the fact that it has been advocated that all persons, all citizens of Canada should be included in this health insurance scheme; so that in stating that the medical profession should have all the rights the osteopathic school of medicine should have no rights—they should be treated as ancillary services which are menial services to be called upon if the medical profession sees fit. I might also point out that in

the United States where osteopathy was born osteopathy is known—in Canada it is not known, as I think you will see very clearly as we proceed with this brief in a moment or two. So we must conclude that one of these must be wrong: either the government of the United States and Congress must be wrong and Dr. Heagerty right, or possibly Dr. Heagerty is wrong and Congress is right. That is a matter that, I think, you people should be the jury to decide.

I should like also to point out that in this great war being waged at the present time the keynote as regards the results expected from this war is an extension generally throughout the world of liberty and freedom. That was the keynote of the Atlantic Charter—freedom. That is what we are fighting for. Now, again in connection with the Act that has been proposed, in response to questions by Mr. Fulford it was brought out that the public, the citizens of Canada—and all citizens are perhaps intended—if they are sick or unwell, may not go to an osteopath physician, they will be obliged to go to a general medical practitioner. Does that not appeal to you as a curtailment of freedom, a negation of what democracy stands for and a negation of the rights of the people?

Finally, before starting on the brief, I should like also to refer to this war. Recently we have been very much cheered by the news of a wonderful victory in Tunisia. There has been co-operation between the many armies fighting this battle against the common enemy. From a numerical standpoint, the leading force has been the British 1st army and the British 8th army which were greatly in the majority and could have taken this attitude toward the lesser armies—the American armies—and that small army of heroes the Free French which wandered over the desert to assist in fighting the enemy, and the Giraud French in the north—but these armies co-operated, and in the words of Winston Churchill, “they vied with one another in friendly rivalry”; and what has been the result of the co-operation? A glorious victory which may shorten this war tremendously. Now, to fight the war against disease is a similar operation. There are large armies. There is that tremendous army which has done wonderful work, and I refer to the work of the medical profession, but we still have disease and suffering with us. As a matter of fact from the standpoint of science, scientific healing is still in its infancy. We have only scratched the surface in knowledge, and it seems to me that where we have so much evidence of the grand results achieved through co-operation that similar co-operation should be the keynote of the various healing professions. We do not see generals like Alexander of the British 1st army and Montgomery of the British 8th army saying to the Americans, “no, we can do nicely without you”. They did not say to the Free French or to the Giraud French, “no, you are ancillary services.” They said, “by all means this is a war and there is a common enemy and let us all get into it and all do the best we can.” The result has been that we have enjoyed so much hearing of the great victory in Tunisia.

Let me refer once again to the United States. The United States ruled through its war man-power commission, through its selective service system, that the study and practice of osteopathy is a critical occupation. These critical occupations, of which there are four, are occupations in which an adequate personnel must be maintained for the health, safety and welfare of the nation. There are four of these critical occupations mentioned in this ruling. They are: the practice of medicine, the practice of osteopathic medicine, the practice of veterinary medicine and the practice of dentistry. Those are the four critical occupations. That means that students attending the osteopath colleges, whether they are in the colleges or whether they are in the preliminary two years of science which is essential before they may enter the osteopathic colleges, shall be exempt from the draft, for the safety and welfare of the nation. Osteopathic physicians in civilian practice are also exempted from the draft because of the shortage of medical doctors. They have to remain in civilian practice. They must not be drafted, for the health and safety of the nation.

Mr. McCANN: Are any of them engaged in military practice?

The WITNESS: I think the last point that I am going to make may answer that question to a certain extent. The final law that I would like to refer to was also passed by the Congress of the United States. We refer to this in more detail in the briefs. It states that graduates from reputable schools of medicine and osteopathy shall be eligible as interneers in the military hospitals. Does that answer the question? They shall be eligible for interneership in the military hospitals. That gives the seal of congressional approval to our education and our colleges and opens by law the army medical service. They are eligible for interneership provided they are graduates from approved colleges of medicine—allopathic medicine or osteopathic medicine.

Mr. McCANN: May I ask this question to make the point clearer? Are there any of the osteopathic graduates in the armed forces in the United States as medical officers of battalions or in charge of hospitals? You said they are there as interneers; they are junior men upon graduation.

The WITNESS: Yes, Mr. Chairman, I would have preferred not to answer that question for the reason that these men are, by government ruling, eligible for interneerships, but what has happened is this: when any of these men attempt to offer their services they have been told politely by the medical services, "well, at the present time there is no room for you; when there is vacancy, yes"; so that while I do not like to refer to it as a dog in the manger attitude on the part of organized medicine, unfortunately, gentlemen, we have the same problem throughout Canada.

The CHAIRMAN: Would the answer to the question be "no"?

The WITNESS: The answer to the question would be "no". We are eligible to go in. The law has opened the way for us, but there has been no room for us. I might refer again to the ancillary services. Apparently, there is no room for more physicians in Canada to fight disease; but I would say that if we were on the verge of success, if disease were just about wiped out, if we knew all about the subject that it is possible to know, I would say that might be a justifiable position to take; but science as regards the fighting of disease is still in its infancy, and I think every medical gentleman will agree to that statement. We have a long long way to go.

Mr. LOCKHART: There have been a number of applications in the United States for admissions, have there not?

The WITNESS: I understand so.

Mr. LOCKHART: Yes, I am so informed.

Mr. BRUCE: May I ask what the situation is in Canada? Have you any of your men serving in the forces of Canada or are they eligible to serve in interneership?

The WITNESS: I wonder, Dr. Bruce, if we might postpone that question. There is a reference in the brief which I think will cover it. In fact, that is a question that I sincerely hope will be gone into; it is a vital question.

I should like to draw your attention to a little booklet at the back of the brief showing osteopathic surgery in connection with osteopathic hospitals. We have appended that as visual evidence. Very frequently our work is referred to as manipulative surgery. Now, you might be expected to believe that when we refer to ourselves as osteopathic physicians and surgeons—you might have in mind manipulative surgery, but that is not so; when we refer to ourselves as osteopathic physicians and surgeons the type of surgery practised is exactly the same as the type of surgery practised which Dr. Bruce so splendidly has exemplified in the province of Ontario.

Your committee is studying a plan for social security, a plan which is to include considerations of health. We, representing a modern, progressive and

successful school of healing, appear before you primarily in the interests of the public health. We will attempt to show where and why osteopathy fits into this plan, and at the same time we would like to tell you a little about osteopathy, what it has accomplished and what it really is. We hope and feel that when you have given careful consideration to the facts contained in this brief, you will agree that any health insurance scheme which may become legal in Canada must include the services of osteopathic physicians and surgeons, for the benefit of the people.

The science of osteopathy, known also as the osteopathic school of medicine, came into being some fifty years ago when Dr. Andrew Taylor Still, its founder, opened the first school of osteopathy with a class of sixteen men and three women. To-day more than 10,600 osteopathic physicians are practising throughout the world, diagnosing and treating every type of disease and suffering as is done by graduates of any other school of medicine.

As was to be expected, osteopathy in reaching its present successful status has had to overcome bitter opposition, numberless obstacles and endless intolerance. In the beginning, as is the case in any departure from established custom, this is understandable, but the present day attitude of intolerance and prejudice on the part of organized medicine is most unfortunate.

And here may I refer to the writings of a medical doctor who writes syndicated articles which appear in the press of the United States mostly but also in some Canadian periodicals. Recently he said, "incidentally, it is high time that regular physicians and osteopathic physicians drop their little jealousies and get together in a spirit of fellowship for their own good and for the good of the public." I thought that was rather appropriate at this point.

Dr. Still, who was a medical doctor, made certain discoveries the truth of which he had proved by years of research and practice. He announced them to the world in 1874 and offered them to his medical colleagues, but these discoveries were so revolutionary, so different, that they were rejected—as has happened so often in medical history. Rather than allow these truths to be lost to the world, he determined that they should prevail, even if he had to start a new school of medicine. This resulted in the birth of osteopathy, and today the Office of Education in Washington, D.C., recognizes the six approved osteopathic colleges in the United States as "institutions of higher learning."

Dr. Still was not unmindful of the good in the then dominant school of practice. From the beginning, he incorporated in his teachings what he considered the good things of medicine and scientific knowledge of his day. This is well exemplified in the charter of the first school of osteopathy, which states, "The object of this corporation is to establish a college of osteopathy, the design of which is to improve our present system of surgery, obstetrics, and the treatment of disease generally, and place the same on a more rational and scientific basis."

That was fifty years ago and you will note that surgery and obstetrics have always been part of the osteopath system of medicine.

The modern osteopathic physician is a well-rounded and well-trained physician. This was recognized by the 70th United States Congress when it enacted Public Law No. 831, An Act to Regulate the Practice of the Healing Art to Protect the Public Health in the District of Columbia, which states "The degree of Doctor of Medicine and Doctor of Osteopathy shall be accorded the same rights and privileges under government regulations."

There is still another contribution for which we are indebted to Dr. Still, and that is the development of a new school of therapy—yes, a competitive one if you like. History has demonstrated abundantly that a system of checks and balances is desirable whether in politics, religion, science, economics or any other field of human activity. We all know what a long struggle it required to attain religious freedom, political freedom and individual freedom. No organization,

no group, can long be entrusted to carry out all of the activities in a particular field. Soon, it, or someone, will gain all privileges and all rights. We see to-day the sad aftermaths of power, the rise of dictator after dictator, suppression of free peoples and the blotting out of the right to express individual opinions.

The medical profession is not only interested in aiding and protecting the public (which we grant) but it is also in part an organization having considerations of their own rights by which they become obsessed with the idea "that good can only flow through the god-head and that the king can do no wrong." So often under the pretext of science and the protection of the public, they place their own opinions and prejudices against a minority in an attempt to keep the status quo. Unfortunately we of the osteopathic profession, not to mention the public, have suffered from these prejudices and the continued opposition of medical doctors. This opposition is usually aimed at either preventing osteopathic physicians from obtaining a licence to practise in a particular state or province, or from practising therein to the full scope of their ability. Invariably every attempt to improve our legislative status, every attempt to be of more service to the public, has met with obstruction, not from the public, not from legislators, but always from one source, from organized medicine.

May I mention that one or two months ago in New Brunswick there was an example of this very thing; an attempt was made to interfere with the legislation concerning the rights of osteopathic physicians in New Brunswick and, gentlemen, this on the part of a powerful profession, because in New Brunswick, gentlemen, there are only four osteopathic physicians. Fortunately, the legislators took up the fight and saved the day as far as osteopathy was concerned, but these are things that surely should not take place.

If our professional services are of value in civilian life, surely they should be available to the armed forces where rigorous training is continuously producing many conditions causing pain and suffering which readily respond to osteopathic care. Yet solely because of the usual opposition our armed forces are denied the right to receive our service. A recent questionnaire elicited the information that since the beginning of the war some 6,000 men from the Canadian armed services had sought the services of osteopathic physicians, at their own expense, to obtain relief they were unable to get from army medical personnel.

And now for fifty years there has been this separate school of practice which has shown virility, a steady growth and open-mindedness to new ideas, yet serving to plant and develop new ideas and also to protect the public from the supreme control of a dominant school. We, as a separate school of medicine, have had an important influence in the healing profession, and in obtaining for the people the right of free choice of their own physician.

Therefore for your consideration we present the following resolution:—

Whereas it has come to our attention that the government of the Dominion of Canada is making a study, through your committee, of the propriety and the desirability of establishing a system of social security for its citizens which system may include a system of health service or health insurance, and

Whereas it is a well-known fact, also shown by statistics, that an increasingly large number of the public are turning to, and depending upon the care of physicians of the osteopathic school of medicine for their health, and

Whereas such osteopathic physicians being graduates of approved colleges of osteopathy and surgery are therefore as adequately trained and qualified to practise, as are those doctors of medicine who are graduates of approved colleges granting the degree "M.D." and

Whereas it has been the steadily maintained policy of osteopathic physicians and surgeons in Canada to bear their full share of responsibility for the health and well-being of the citizens of their community, not only in private practice but also in taking care of great numbers of the indigent sick, without remuneration, and

Whereas the Royal Canadian Air Force, recognizing the demand for osteopathy, has recently opened its doors for the enlistment of osteopathic physicians in their professional capacity (a small number having already enlisted and been accepted), and has requested that lectures on osteopathy be prepared and delivered by leading osteopathic physicians at the 18th School of Aviation Medicine in Toronto, the précis of the lectures to be copied and distributed to the medical branch in order that they may intelligently make the best use of osteopathic services, and

Whereas the only fair and democratic method of administering health insurance would of necessity entitle each participating citizen to the right and privilege of employing the qualified practitioner of his choice, irrespective of the school or mode of practice,

Therefore, be it resolved that we, the members of the Canadian Osteopathic Association, representing osteopathy throughout Canada, do petition this committee to recommend to the legislature of the Dominion of Canada, that they shall by law include the services of osteopathic physicians and surgeons in any scheme of health insurance for the citizens of this country, on the same basis and under the same regulations as for any other branch of the healing art, and that those administering the service shall not, by administrative ruling, prevent a citizen of Canada from receiving the services of an osteopathic physician if said citizen is eligible for medical care under the provisions of the proposed insurance system.

For the purpose of clarifying, to this committee, the position of the osteopathic profession, we take this opportunity of amplifying the foregoing resolution.

It is unfortunate that in the Dominion of Canada, an appalling ignorance regarding the osteopathic school of practice exists, an ignorance in part due to our paucity of numbers, but perhaps more the result of deliberate propaganda fostered by organizations representing rival professions, often for legislative purposes. The following statements of fact will make reference to the status of osteopathy as recognized by the governments and the people of the United States. Every statement is authentic and can be readily verified.

Facts Concerning Osteopathy

Osteopathy is in reality a complete system of healing co-extensive with the practice of medicine. It covers the whole field of disease, diagnosis and treatment, and includes surgery and obstetrics. It is recognized as such, almost universally, in the United States where it originated, where it is known, and where it is relied upon for health by millions.

Since experience has shown that the opponents of osteopathy frequently make stereotyped, erroneous statements about our profession, we have to say the following:—

Osteopathy is not and never was a drugless system of healing.

It is not a system of rubbing or massage.

It has no connection whatever with chiropractic.

It is not based on any theory of dislocation of spinal or other joints.

Osteopathy is not synonymous with "manipulation", nor is Medicine synonymous with "health".

There is a little difference, I believe, between health insurance and medical insurance.

Osteopathy is not something learned at a short course school or by correspondence.

Osteopathy does not teach that bones press on nerves and thus cause disease.

It is not restricted to the treatment of certain ailments or certain classes of diseases, and is therefore not, per se, a specialty. (For this reason the choice of an osteopathic physician, by any citizen included under the proposed plan of health insurance, must not be contingent upon the recommendation of a medical adviser, or after consultation with him.)

Osteopathic Education

Osteopathy is taught exclusively in the United States in six approved colleges of osteopathy and surgery, each of which has its own hospital. These colleges are classed as institutions of higher learning by the United States Office of Education at Washington, D.C.

Prerequisite for entrance to these approved colleges is, graduation from high school, and the completion of a two year college pre-medical science course, which includes chemistry, physics, biology, English, etc.

Professional education in a College of Osteopathy and Surgery, following the satisfactory completion of the pre-medical course, consists of four years of nine months each, a total average of 4,668 hours of lecture and laboratory work. During the last two years of their course, osteopathic students receive clinical experience in the public clinics and hospitals operated in conjunction with each college. They are therefore, on graduation, fully prepared by experience to enter into general practice as osteopathic physicians.

Text books approved for study in osteopathic colleges include the same text books as used in non-osteopathic medical colleges, and in addition osteopathic texts dealing with the principles and practice of osteopathy.

A comparison of the curricula of all approved osteopathic colleges with those of approved medical colleges, will serve to show that an osteopathic student is taught all subjects required in medical colleges, in addition to the strictly osteopathic subjects.

Curriculum of an Osteopathic College consists of the following subjects:—

Basic Sciences: Anatomy and Dissection; Histology; Embryology; Physiology; Chemistry—Inorganic, Organic, Biological; Pathology; Bacteriology; Hygiene and Sanitation—Public Health.

Supplemental Therapeutics: Pharmacology; Toxicology; Anaesthesiology; Narcosis and Antisepsis; Biological Therapeutics—Vaccines, Sera, Protein Sensitization and Diagnosis, Endocrine therapy.

Practice of Osteopathy and Osteopathic Therapeutics: History of Osteopathy; Principles of Osteopathy; Osteopathic Technique; Comparative Therapeutics; Laboratory Diagnosis; Physical Diagnosis; Symptomatic Diagnosis; Osteopathic Diagnosis; Diseases of the Gastro-Intestinal System; Diseases of the Cardio-vascular System; Diseases of the Respiratory System; Diseases of the Genito-Urinary System; Diseases of the Haematopoietic System; Diseases of Locomotion; Gynecology; Acute Infectious Diseases; Nervous and Mental Diseases—Psychiatry; Venereal Diseases; Parasitology and Tropical Medicine; Dermatology; Proctology; Pediatrics; Endocrinology; Podiatry; Dietetics; Physiotherapy; X-ray.

Surgery: General Surgery—Major and Minor Surgery; Orthopedic Surgery; Ophthalmology; Otolaryngology; Urology.

Obstetrics: Physiotherapy, it should be noted, is an adjunct to osteopathy just as it is an adjunct to the practice of medicine.

Osteopathic Hospitals and Clinics

There are 156 hospitals and 75 clinics, staffed by osteopathic physicians and surgeons in the United States. These clinics offer various osteopathic services, some being devoted to the care of infants and children, others to specific diseases and others to general conditions. The hospitals cover the whole field of medicine including obstetrics and surgery and its special branches.

Noteworthy among the osteopathic institutions is the Still-Hildreth Osteopathic Sanatorium, located at Macon, Missouri, for the osteopathic treatment of nervous and mental diseases. Outstanding success has been achieved in this field.

The osteopathic unit of the Los Angeles County Hospital has also made an enviable record for itself in caring for all types of diseases.

It is of interest to note that the citizens of Philadelphia donated one and one-half million dollars to the osteopathic profession for the erection of an osteopathic hospital and college.

Osteopathic Specialties

Among the specialties in the osteopathic profession are included the following:—Surgery, Obstetrics, Gynecology, Orthopedics, Eye, Ear, Nose and Throat, Neuro-psychiatry, Proctology, Herniology, Pediatrics, Radiology, Podiatry, Pathology, Acute Diseases and others.

United States Recognition of Osteopathy

This recognition achieved by osteopathy in the United States from the federal and state governments indicates the confidence and respect with which osteopathy is regarded.

From the Occupational Bulletin No. 41, dated December 14, 1942, signed by Lewis B. Hershey, Director, National Headquarters, Selective Service System, Washington, D.C., we quote referring to osteopathic physicians:—

if engaged in the practice of their profession (they), are in a position to perform vital service in activities essential to war production and to the support of the war effort, and in activities the maintenance of which is necessary to the health, safety, and welfare of the nation.

The War Manpower Commission includes osteopathy among the four "critical occupations, which for the proper discharge of the duties involved, require a high degree of training, qualification or skill." (Four critical occupations—medicine, dentistry, veterinary medicine, osteopathy).

The War Manpower Commission has certified that "there are serious shortages of persons trained, qualified, or skilled to engage in these critical occupations. Accordingly, careful consideration for occupational classification should be given to all persons trained, qualified or skilled in these critical occupations and engaged in activities essential to the health, safety, and welfare, necessary to war production and essential to the support of the war effort, and persons in training therefor."

Public Law No. 831, an Act to Regulate the Practice of the Healing Art to Protect the Public Health in the District of Columbia, enacted by the 70th United States Congress, states "The degree of Doctor of Medicine and Doctor of Osteopathy shall be accorded the same rights and privileges under government regulations."

A Military Appropriation Act for ten and one-half billion dollars, enacted for the national defence by the 77th congress and signed by President Roosevelt includes a provision and appropriation for the employment by the War Depart-

ment Medical Corps of internes who are graduates or who have successfully completed at least four years professional training in reputable schools of medicine or osteopathy, thus giving congressional approval of osteopathic education for the purpose of medical service in the army's hospitals.

The 75th United States congress amended the United States Employees' Compensation Act to make the services of osteopathic hospitals and physicians available to federal civilian employees injured in line of duty.

The National Health Conference called by President Roosevelt in July 1938, officially invited the osteopathic profession to participate in plans for the national health program. (Similar conferences were called in Canada recently in connection with the proposed health insurance plan, but here, osteopathy was completely ignored despite our requests to participate.)

Osteopathy is also actively represented on the national council for mothers and babies, in the Children's Bureau, United States Department of Labour. The profession is also co-operating wherever possible under the social security act. It participated in the White House Conference on Children in a Democracy, and in the Eighth Pan-American Scientific Congress.

Here in Canada, members of boards of health, health officers, coroners, etc., are almost invariably doctors of medicine. Throughout the United States, however, we find osteopathic physicians on state boards of health, county boards of health, city boards of health; as city health officers, county health officers, town health officers, township health officers; as city coroners, county coroners; on state medical advisory committees, county medical advisory committees, city medical advisory committees.

Osteopathic physicians serve as staff physicians for athletic departments of universities, colleges, public and private schools. Many professional athletic clubs are never without the services of an osteopathic physician during their active season. There are also a great number of industrial and commercial organizations which employ osteopathic physicians and surgeons as full time staff doctors.

Insurance companies and casualty companies accept the reports of osteopathic physicians in accident and sick benefit cases. An increasing number of companies have already written into their policies wording such as:—

"No indemnity (for sickness or injury) will be paid for any period of disability during which the insured is not under the regular care and attendance of a legally qualified physician, surgeon or osteopath other than himself."

Every state and territory in the union has made legal the practice of osteopathy. Graduates in osteopathy are recognized as doctors, physicians and surgeons, take the same or equivalent examinations before licensing boards of these states as do graduates of other schools of medicine. These boards are set up by the state government.

In 29 states, examining boards are exclusively osteopathic doctors.

In 14 states, examining boards are osteopathic and medical doctors.

In 5 states, osteopathic graduates are examined by boards composed entirely of medical doctors.

Scope of Practice

The scope of practice of osteopathic physicians and surgeons in the United States is on a par with that of medical doctors in most states. In five states, osteopathic physicians do not use drugs or do surgery.

In the provinces of British Columbia and Alberta, osteopathic physicians practice surgery and obstetrics, use drugs and sign birth and death certificates, etc.

In Ontario, however, perhaps due mainly to our small numbers—osteopathic physicians being outnumbered by medical physicians by fifty to one—restrictive legislation has ensued. The result being that osteopathic physicians have been unjustly classified as drugless practitioners—which they never have been—and have been prevented from using their skill and education for the benefit of the public in many directions, such as in surgery, obstetrics, etc., which have become temporarily, medical monopolies.

This is regrettable since, owing to these adverse laws restricting the full use of their training, many Canadians who have studied osteopathy in the United States prefer to remain there where fairer and more equitable laws prevail. They become American citizens and are lost to Canada.

This is one reason for our small numbers in Canada.

Mr. McCANN: What is the opposition? Do you mean by the usual opposition the opposition to organized osteopathic medicine?

Dr. EGGLESTON: Yes, the opposition to organized osteopathic medicine.

Mr. McCANN: Do you not know that allopathic medicine has nothing to do with regard to the armed forces; that matter comes under the military?

Dr. EGGLESTON: I think that point—

Mr. McCANN: It is easy to make a statement like that, but what is your proof for that statement? Has there been any opposition on the part of the Canadian Medical Association which includes within its numbers the great bulk of the medical practitioners of Canada? Has it made any official opposition either to the military forces or to those in control of the medical forces to keep the osteopathic physicians outside?

The CHAIRMAN: Order, please. We are not discussing at the moment the methods or the practice in the military services. I prefer that Dr. DeJardine proceed with his brief and then he can answer the questions which are separate from argument; we are not here to argue.

The WITNESS: Thank you. I think that matter will be clear before the end of the brief.

The CHAIRMAN: Will you proceed please?

The WITNESS: A questionnaire recently sent throughout Canada to osteopathic physicians elicited the following interesting information. During the last decade 150 osteopathic physicians cared for approximately 550,000 persons in Canada, and since the beginning of the war, almost, and now probably more than, 6,000 members of the Canadian armed forces came to their private osteopathic physician for necessary treatment which was not available otherwise.

I may say that every day we have someone from the armed services coming into our offices for the aid of osteopathy.

The Canadian Osteopathic Association is sympathetic with the labours of your committee in making a study of this proposal for drastic changes in the economical life of the people of the dominion. It recognizes that there are problems involved other than those having to do with medical care. However, Canadian osteopathic physicians are well aware that, in setting up such a social service as is proposed, the rights of the individual citizen must be maintained in order to preserve the democracy which so characterizes the Canadian government.

In the process of setting up health insurance, the history of health insurance in foreign countries and in England is of such nature as to give the most grave concern to thoughtful physicians. The imposing of an authority and an intermediary between the physician and his patient which, to some degree at least, becomes so necessary under any health insurance scheme, is looked upon with misgivings by most physicians. The relationship between physician and patient is of a very close personal nature and the services of physicians to patients

cannot be most successful unless that person relationship is preserved to the highest degree and the confidence of one in the other promoted thereby. Physicians then are apt to fear that any administrative body setting down a mass of generalized rules so necessary to the successful management of a complicated socio-economic problem may be destructive in the end, rather than promotional of the public health. The effect of politics on social services under government control cannot always be predicted. The very unfamiliarity on the part of administration and of physicians, who would provide the service in such a plan, in itself is, temporarily at least, a danger clearly recognized by physicians as possibly detrimental to the public health.

However, the Canadian osteopathic physicians are not unmindful of the high purposes and social responsibilities which may be involved in the committee's considerations. Admittedly the health of the people of Canada is not what it should be nor, indeed, is it what it could be. It seems entirely conceivable that one of the deterring reasons for this unsatisfactory state of the health of the people of the country is involved in the socio-economic condition by which medical service is distributed. Medical services become rapidly more expensive. It actually costs more to deliver that service than it has ever done before and, as new developments in the practice of the healing art make themselves steadily available, the expense has steadily increased and bids fair to increase further and thus the expense of illness becomes more and more of a burden on a larger proportion of the people—a burden which in some instances they are absolutely unable to support.

It is believed that there are not now, and that there never have been, a sufficiently large number of physicians and surgeons in Canada to supply all the needs of the citizens and that, if an economic system is instituted by which an adequate service may be given to all the citizens of the dominion, there will develop immediately the very obvious situation of a very great shortage of physicians and other health workers.

Many other considerations may present themselves, but if it is found by the Canadian government that it is necessary, desirable, or possible to institute a comprehensive scheme for the distribution of health service under government supervision in the dominion, then we must point out that the least possible interference between patient and physician is highly desirable of such insurance scheme, if indeed, it is not an absolute essential to its success. As osteopathic physicians offer a service which is plainly enough in demand by a very large proportion of the Canadian people, therefore, osteopathic physicians feel it is a government obligation to set up any such scheme of insurance in such manner as to prevent interference with the right of any eligible Canadian citizen to avail himself of the service of any qualified physician of his choice, in the dominion.

The following quotation, a clause from Section 7 of the Revised Model Health Insurance Bill of the American Association for Social Security is pertinent.

This is known as the Epstein bill:

Section 7—ADMINISTRATION OF HEALTH INSURANCE (16-a)—

Every general medical and dental practitioner duly licensed to practise in the State (without discrimination against any school or mode of practice which is lawful in the State), and any number of such practitioners practising as a group shall have the right to be included in the list of those furnishing the medical benefits provided for, etc.

Referring to a statement concerning osteopathy in the excellent booklet "Health On The March" issued by the Canadian Federation of Agriculture (page 28):—

To our minds there are two procedures to be followed: either that these services (osteopathy) should be recognized under a National plan, or that their work should be incorporated into the course of medical training. This situation the public expects to be clarified.

We would like to assist in clarifying this situation, by stating that it is our belief that any attempt to incorporate osteopathy into a medical course must of necessity fail. Truly, manipulation might be taught, in fact it is being taught, but this is a far cry from osteopathy, for manipulation is not osteopathy, and manipulation without the osteopathic concept becomes sterile.

At the present time, with the science and art of healing still in its infancy, it is neither plausible nor desirable that the various schools of medical thought be combined even if it were possible. No school of healing remotely approaches complete knowledge of the human being or his diseases, and until that knowledge exists divergence of thought is not only unavoidable, but is a necessity in order to stimulate advancement in the fight against disease.

At the present time, the basic concept of the osteopathic school of medicine differs so radically from that of the dominant school of medicine, that a union of the two is not only practically impossible but could produce nothing but incompetent hybrids, since it is the concept that determines the treatment.

From a recent editorial in the journal of the American Medical Association, referring to the Beveridge report and plans for social security, we quote:—

Finally comes the principle of free choice. The very basis of the American democracy is free choice: free choice of the school one attends, the newspaper one reads, the church in which one worships, the store in which one make one's purchases, the car in which one rides, the bank in which one keeps one's funds, the hospital in which one receives hospital care, the physician and the lawyer whom one consults.

This democratic principle of free choice of doctor has also received the endorsement of the Canadian Medical Association.

During the fifty years the school of osteopathic medicine has existed, the leaven of osteopathy has been working. Medical ideas and concepts are changing, and little by little are coming closer to those that are osteopathic.

Some textbooks on some phases of healing written by medical doctors could almost be thought to have been written by osteopathic physicians.

We feel that the science and art of healing is still in its infancy—as every honest doctor in every branch of medicine will admit—and in this time of research and progress in every school of healing, we feel that it would be a great mistake to even consider giving over the lives of all your fellow Canadians into the hands of one school of medical thought, to the exclusion of all others. Doubtless there is no intention to do anything of the sort, but after scanning the proposals submitted by the Canadian Medical Association, one is impelled to the conclusion that a serious attempt to obtain a medical dictatorship is being proposed, despite magnanimous democratic references to free choice of physicians, etc. the choice referred to, of course, being choice of doctors of the dominant school of medicine, which is no choice at all.

The suggestion that other schools of healing will be recognized as "auxiliary services", to be made use of as seen fit by the medical doctors is unsatisfactory. Unfortunately the experience of osteopathy has been, that almost invariably with the majority of our patients, every conceivable subterfuge has been used

in an endeavour to prevent the patient from receiving osteopathic services. When the patient finally comes, he usually comes in spite of this medical advice.

The frequent insistence on high standards of medical services sounds wonderful. A few years ago, osteopathy was discussed at a medical meeting held in Ottawa, when, as we learned from the press, it was pointed out that it was not the ignorant classes that were taking to osteopathy but the intelligentia, the leaders in all walks of life. These, it should be noted, are people who are able to obtain the highest standards of medical services, yet they come to osteopathy. It is no secret that British Royalty has for many years availed itself of osteopathic services, indeed one of the first acts of the late Duke of Kent on arrival in Ottawa on his last trip was to obtain osteopathic treatment.

You on this committee are engaged in a wonderful work, entailing tremendous responsibility. Your objectives are idealistic, almost Utopian. In such an improved existence, surely there should be no room for the traditional medical intolerance of anything new and different. Surely there is no room for the malice that in Ontario succeeded in placing on the statute books, a law depriving a group of physicians of the right to use their degree and title, "doctor", giving Ontario the questionable distinction of being the only place in the entire world to enact such puerile class legislation. Surely in this new era, a healthier, more charitable spirit must prevail.

In a recent talk by Winston Churchill he referred to the British American and French armies in Algeria as "vieing with one another in friendly rivalry." Is this not the spirit that should exist between the dominant and osteopathic schools of medicine? We believe so.

In conclusion, it should be kept in mind that all qualified osteopathic physicians and surgeons, whether practising in Canada or in the United States have graduated from approved American Colleges of Osteopathy. Therefore may we respectfully suggest that in any social security or health insurance law, wherever the words "doctor", "physician", "surgeon", or "general practitioner" appear in such an Act, it shall be understood to include osteopathic physicians on the same basis as physicians of any other school of practice. May we also respectfully recommend:—

1. That the dominion government enact legislation regulating the practice of the healing arts in Canada similar to that enacted by the United States Congress in Public Law #831, viz. "The degrees doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under government regulations."

2. That since the public will be compelled to pay for the proposed health services, the public should control the administration of these services throughout the dominion, in every case. From the standpoint of the citizens and the interests of the general community, the most important thing about any social measure is that it should be democratically administered, that it should not be controlled by any group and that it should not be operated in the interests of any specific group or groups. The principle of democracy must not be violated.

3. That the Canadian government should not force its citizens to yield servile obedience to one school of healing and refuse these citizens the liberty of obtaining, from other schools of practice, relief from disease and suffering which often they alone can supply.

4. That since under any compulsory health insurance scheme all citizens should benefit equally, therefore any minority that does not subscribe to orthodox medical treatment must not be coerced into contributing to medical insurance. Under the proposed bill, the insurance cannot correctly be termed "health insurance" but rather "medical insurance" since it provides only the services of one school of practice, orthodox medicine.

5. That if community hospitals are established throughout Canada, these hospitals should be free to all citizens as well as all schools of healing. That all grants specified in the draft bill and all funds allotted for research on health matters should likewise be made available to all branches of the healing arts.

6. That the Canadian government, through its Department of Pensions and National Health, urge closer co-operation and a friendlier spirit between the schools of allopathic and osteopathic medicine in order that a thorough house cleaning may result and that what is obsolete may be discarded. Free exchange of ideas would make for greater progress in the practice of the healing arts but this must be done in a spirit of good will and comradeship and not in the master and slave spirit as proposed in the health insurance bill.

The CHAIRMAN: Now, gentlemen, are you ready for questions? Dr. Bruce, have you a question?

By Mr. Bruce:

Q. This document is a rather amazing one to me. I do not know that it answers many of the questions I would like to have answered. I am still at a loss to know what osteopathy is. Would you please explain?—A. Mr. Chairman, may I ask Dr. Eggleston to answer that question.

Dr. EGGLESTON: Mr. Chairman, it is extremely difficult to define any school of practice because a school of practice is a progressive, advancing thing, and I doubt if the Hon. Dr. Bruce would undertake to define the allopathic school of medicine, limiting it by to-day's standards for to-morrow when it shall be a bigger and better thing. The osteopathic school of medicine is based on certain concepts of biological approach to therapeutics. I should like to take the opportunity of reading what we consider a few of the basic principles underlying our osteopathic concepts.

We believe that the inherent capacity of the human organism to react to injurious influences brought to play upon or within it is more important in the treatment of and recovery from disease than the injurious factors capable of provoking the disease. That the major objective in treatment is to establish or make available within the organism the highest level of reacting efficiency possible under the circumstances. That structural and mechanical factors which constitute definite impediments to highest reacting efficiency frequently are present within the body. We further believe that manipulation can be applied to the body for the purpose of correcting many structural and mechanical disturbances and/or for the purpose of re-establishing the homeostatic mechanism in the presence of disease.

Does that answer the hon. gentleman's question?

Q. I am almost as mystified as I was before.

Mr. HOWDEN: I gather from a perusal of this brief and from hearing it read that the success of osteopathy is based largely on the same principles of study, anatomy, physiology and histology, as the general medical profession. If, therefore, the men of osteopathic science base their search for the principles of health on the same study as we of the orthodox practice of medicine what, may I ask, is the outstanding difference between their science and ours?

The WITNESS: Mr. Chairman, may I again ask Dr. Eggleston to answer Dr. Howden's question?

Dr. EGGLESTON: Mr. Chairman, I may have to repeat my answer to one of Dr. Bruce's questions. Our main divergence from, shall I say, the allopathic school of medicine is an attempt to find the biological approach to disease. We

believe that disease is not the thing, not an entity that attacks the body; it is a process, a biological process which the body attempts to overcome, or to fight against, organisms, toxins and injurious elements that are brought to bear upon it within the body.

Mr. HOWDEN: Where do they come from?

Dr. EGGLESTON: Bacteria, poisons; they come from the same place as in your diagnosis.

Mr. HOWDEN: I gathered from what you said a moment ago that that was the outstanding difference between us; that you did not recognize these extraneous organisms.

Dr. EGGLESTON: I can only submit in answer to that the catalogue of one of our educational institutions. We study the same basic sciences, we see the same germs and they look the same, and they are cultured the same in our laboratories. The body reacts the same. We believe that in attempting to overcome that it is more important that the reacting efficiency of that individual body be attended first. We recognize that any influence that may be brought to bear on the degree of effectiveness of this protecting mechanism of the body is good therapy; but we also believe that we must look to the patient as well as to the disease.

Mr. HOWDEN: I take it that I am correct in saying that your conception of disease is much the same as ours?

Dr. EGGLESTON: Absolutely.

Mr. KINLEY: The Nurse Kenny treatment of infantile paralysis has engaged the attention of the medical profession throughout Canada. Is that osteopathy, or is it something that is a factor in the other school of the medical profession?

The WITNESS: May I answer that question? The principal underlying the Kenny treatment is entirely in line with the osteopathic concepts. Nurse Kenny, of course, has not studied osteopathy but accidentally, more or less, she has stumbled on certain things. The treatment as outlined in our colleges is very similar. I think some of the things which she does, possibly, are done perhaps a little more scientifically. She has interpreted infantile paralysis from her own angle and is not entirely scientific, but there is no question about it that she has got results, and in that case we have for years had good results in the treatment of infantile paralysis when we have had an opportunity to treat the disease. It is so seldom, of course, in Ontario that we ever did get a chance to treat the disease in the acute stages, and that is when the really effective therapy must be done. Once the damage has been done by the virus, once the nerve cells have been destroyed by that virus, you cannot replace dead tissue. We can improve the tissues that are left where there is life left in the nerves and we can restore those conditions back to normal because of the pathology behind them, as the medical gentlemen here understand.

Mr. McILRAITH: I understand that there are some osteopaths in the Royal Canadian Air Force, and I should like to have any information you can give us on that point with regard to the arrangement and the status?

The WITNESS: I shall be very glad to do what I can. I think I will ask Dr. Eggleston to answer that question.

Dr. EGGLESTON: The Royal Canadian Air Force established a means whereby osteopath physicians might be enlisted to do their own work in the medical branch of the air force, and to explain that a little more might I read a copy of the recruiting bulletin under which that establishment is made:—

It is proposed to enlist a limited number of osteopaths. They will be required to attend to all cases referred to them by the medical officers. It is expected that they will be employed at the larger units and at air force headquarters.

While the establishment has not yet been approved it is desired that applications from suitable candidates be forwarded at the earliest possible date to air force headquarters for consideration under Manning Order M.10/25.

Now, that bulletin goes on to list the qualifications necessary and gives the list of names of individuals in the Canadian Osteopathic Association. Following the establishment of this bulletin some of our men enlisted at the level of acting sergeant under the understanding, as discussed by correspondence with Air Minister Power and Air Vice Marshal Sully, that promotion in the air force would depend entirely upon ability to gain such promotion. At that time the Canadian Osteopathic Association was invited by Air Commodore Ryan, then director of medical services for the air force, to deliver a series of lectures on the practice of osteopathy to the 18th School of Aviation Medicine. This invitation was accepted and the lectures were prepared. The opening of the 18th School of Medicine was postponed and we were to be informed at a later date when the school would open its sessions and it was hoped that we would be able to meet the requirements. Between the postponement and the actual holding of the school of aviation medicine there was a change in the personnel of the director of medical services, and somewhere in that change the invitation to deliver these lectures has become lost. In reply to inquiries as to what has been done we have a letter here from Group Captain J. W. Tice, Air Commodore, Director of Medical Services, which says:—

I have discussed the matter of the lectures referred by you with various consultants of the medical branch and regret to say that I see no indication at the present time that such lectures are necessary. You will appreciate that this, my opinion, is at variance with that of my predecessor and it is regretted if this has caused you any inconvenience.

The inconvenience that this has caused is the fact that we have enlisted in the medical branch of the air force eight osteopath physicians who enlisted in the full spirit of co-operation hoping to be able to render services to the air force. They have not been able to get the opportunity to practice as was outlined in the proposal for enlistment. They have not been given that opportunity to have their services explained through the lectures that were to be given on the invitation of the former director of medical services.

Mr. SHAW: Have those men been offered their discharge?

Dr. EGGLESTON: I cannot answer that directly. I think some other member of the association could do so.

Mr. McCANN: How do you account for the change in view between Dr. Tice and his predecessor?

Dr. EGGLESTON: I can only answer that by saying that I cannot look into Dr. Tice's mind.

The CHAIRMAN: Would not the osteopaths to whom you refer as being in the air force be correctly classified as ancillary services—the term to which you object—doing work or giving treatments under the instructions of medical officers who refer cases to them?

Dr. EGGLESTON: The boys who were recruited were to do their work and use osteopathy.

The CHAIRMAN: Independently of the medical officers?

Dr. EGGLESTON: No, under the direction of the medical officers. The arguments we make are two: first, that they were enlisted with the opportunity of advancing as advancement was merited—

The CHAIRMAN: Not advancing in independence?

Dr. EGGLESTON: No, advancing in rank.

The CHAIRMAN: But not in independence?

Dr. EGGLESTON: Not in independence; under the present set-up, no. At present the rank has been frozen at the level of sergeants for a man with a college training and a professional degree.

The CHAIRMAN: I am not speaking of the rank, but the authority within the service; will you emphasize that?

Dr. EGGLESTON: I can hardly distinguish between rank and authority.

The CHAIRMAN: You said that the osteopath cannot act independently of the medical officer.

Dr. EGGLESTON: Under the present establishment he can only treat those cases which are referred to him.

The CHAIRMAN: That clears that up.

Dr. EGGLESTON: Unfortunately, he is not being permitted to use any osteopathic therapy.

Mr. GERSHAW: May I ask if these practising osteopaths use such things as insulin for diabetes or these sulfa drugs and antitoxins in diphtheria?

The WITNESS: By all means. We are physicians and surgeons. That is part of this miasma I referred to in the beginning of my talk. In Ontario we are classified as drugless which we never have been. Where our practice is not restricted, as it is in Ontario, osteopathic physicians use antitoxins in diphtheria and they always have, and they are now using the sulfa drugs. Perhaps not as promiscuously as are the medical men, but I know several medical men in Toronto who have given them up because of the fatality and the after-effect. Certainly, in our own practice we have had innumerable cases that have been almost incapacitated for weeks and months following the use of sulfa drugs. They may have saved lives, we do not know, but it was certainly at a big cost. Certainly, all these are included in osteopathic medicine where we are not restricted in our practice.

Mr. SHAW: There is a vital principle involved in the statement of Dr. Eggleston. He has stated that eight osteopaths have enlisted in the air force with the clear-cut understanding that they would be permitted to practice osteopathy, maybe in an auxiliary capacity. Now, we learn that that has not been permitted. My question was: are these men still obliged to remain in the air force. Dr. Eggleston indicated that probably another doctor would be able to answer that question.

Dr. EGGLESTON: The secretary-treasurer of our Canadian association might be able to explain from correspondence better than I could. There is no data I can give you on attempts to get out of the service. The boys in the service now are still in hopes of being able to co-operate and to render the service that they feel they have to offer in the conduct of the war.

Dr. PARSONS: The answer is definitely no. They have been given no opportunity of remustering or to get out of the service. They are advised to do only what the medical officer instructs them to do, and so far it does not include the practice of osteopathy.

The CHAIRMAN: Have they applied for remustering?

Dr. PARSONS: It has been suggested by myself to the air force that they be given that opportunity but so far nothing has been done.

Mr. COTE: In what capacity are they serving just now?

Dr. PARSONS: They are serving as sergeants in the medical service. Usually they are attached to a physiotherapy department which involves the application of massage, the use of liniments or heat lamps or shortwave machines which are all only adjunct to the treatment by osteopathy.

Mr. McCANN: Mr. Chairman, the brief which has been presented to us this morning by the osteopaths of Canada, and similar briefs which have been presented on former occasions before this committee by the chiropractors, the Christian Scientists, the Medical Liberty League, and several others that I could mention have, in my opinion, dealt very much with conditions as they obtain in the United States. Now, what we want to hear before this committee is what the conditions are in Canada and how they will fit in with the scheme of health insurance. I would direct the attention of members of the committee, in contrast, to the type of briefs which have been presented here by the Canadian Public Health Association, the Canadian Medical Association and different organizations of the allopathic school, which attempted to give to the committee some conception of conditions as they obtain in this country and the provision which is being made for medical education and for hospitalization and for the carrying out of a system of health insurance should it be put into effect. Now, the gentleman who has presented the brief states that 150 osteopathic physicians in Canada have treated in the last ten years 550,000 persons. I presume that that means 550,000 persons per year? Or does he mean in the ten years?

The WITNESS: During the ten years, as near as we can estimate a figure like that.

Mr. McCANN: That would represent approximately 55,000 people per year. Is that right?

Dr. McVITY: That represents 55,000 different people, not 55,000 individual treatments given?

Mr. McCANN: If that were the case the 150 men were treating 55,000 people in a year and if you figure that out you have one man treating approximately 30,000 people.

Mr. FULFORD: Oh, no.

Mr. McCANN: I mean 3,500 people.

The WITNESS: Not even that many; about 400.

The CHAIRMAN: Four hundred.

The WITNESS: Four hundred is the answer—less than 400.

Mr. McCANN: Figure it out for yourself on the basis of 150 osteopaths. It depends on whether they mean 55,000 per year or 550,000. I am taking it for granted that what is stated in this brief is correct, that 150 osteopath physicians have treated 550,000 persons in ten years. Is that right?

The WITNESS: During the whole time.

Mr. McCANN: Take it any way you like. If 150 people are treating 55,000 then you haven't got a big practice, and if they are treating 550,000 per year then they are attempting to render a service to too many people, because the average for medical practitioners is one practitioner for every 1,000 or 1,100 people, and while it is true that in a great many districts in the country they are not well serviced because of the scarcity of doctors at the present time, I submit that it would be absolutely impossible for the osteopathic physicians in Canada to give any kind of adequate treatment to the civilian population.

Mr. SHAW: Did not someone indicate that one doctor in an industrial centre took care of 2,500 patients?

Mr. McCANN: There is a difference between an industrial plant and a scattered community where you are dealing with people in their homes. When you are treating people in industrial concerns you have facilities for treating them there. Now, I should like to have some information with respect to the standing and the number of the osteopathic physicians in this country. Is there any recognized school, is there any recognized university in this country that

has set up a chair for the teaching of the osteopathic branch of medicine? I do not think there has been one. Let us take the situation in Canada. I can understand the opposition there has been. These men are all graduates of schools in another country. It is quite reasonable that they be not accepted by any province in Canada unless they conform with what is laid down as basic professional education. They are accepted in two provinces, Alberta and British Columbia. It has been pointed out by one of the gentlemen who spoke with reference to the position of the osteopaths in the medical services of the armed forces that they have been accepted into the air force, but it is very clearly stated there that their services are to be ancillary services—that is what the gentleman read—under the direction of the medical officer in charge; is not that correct?

The WITNESS: Not quite; they are to treat cases referred to them by the medical men.

Mr. McCANN: Exactly.

The WITNESS: If I refer a case to you I do not tell you to do this and to do that. If you refer a case to me—and many medical men in Toronto refer cases to us—we always make our own diagnoses and decide what treatment is necessary in a given case. We have tried to show you that we are physicians and surgeons, but we cannot use a thermometer and we cannot use a stethoscope, and we are not allowed to take blood pressure—we are not allowed to do anything. We are merely ancillary services; we are merely to be maid servants.

Mr. McCANN: Your position is entirely different in time of war and it is entirely different in the armed forces than your position would be in civilian service, and in this health insurance scheme it is pointed out that service such as yours is under the direction of the medical profession and may be used as an ancillary service. That is exactly the attitude that has been taken by the medical authorities in the armed services, because they must assume the responsibility. Now, then, you point out with reference to osteopathic physicians that in certain parts of the United States they are allowed to make reports which are accepted by accident and health insurance companies. The question I want to ask is this: is an examination of individuals by osteopathic physicians for life insurance accepted in any of those states?

Dr. McVITY: Dr. McCann, I do not have those figures but they could be given. We could supply you with them; but I could answer it in this way, that the question does not refer to the United States. Accident and health insurance companies accept the report of our physicians right here in Canada.

Mr. McCANN: In what parts?

Dr. McVITY: And they include it right in their policy as was stated in the brief.

Mr. McCANN: What type of insurance?

Dr. McVITY: Accident and health.

Mr. McCANN: I am asking you about straight life insurance in Canada. Do those companies accept the examination of an osteopathic physician when it comes to accepting a life risk? I think not.

Mr. McVITY: The answer is yes. Life insurance companies do accept our certificates.

Mr. McCANN: With what companies?

Dr. McVITY: I cannot name them now, but we can supply you with those certificates.

Mr. McCANN: I did not know that. I understood it was so as far as concerned accident and sick benefit cases, but not life insurance cases.

Now, there is a lot made in this brief with reference to intolerance to the branch of the medical profession with respect to osteopathy. There is nothing in your brief or any brief which has been submitted here, which does not accept orthodox medicine, to substantiate that statement, and there is no evidence, I submit, that there is any truth in that statement that there has been intolerance or prejudice as far as your profession has gone. It is the people of Canada who have to be considered and who we are trying to protect. There is an entire misconception there. We want to give service to 11,000,000 people in this country and you people have not the facilities to render service to 1,000,000 if the matter were left to your particular branch in medicine and to all the combination of people who are drugless practitioners. The aim of the medical profession has been to render service to the great bulk of the people and they, in my judgment, are the only ones both from the standpoint of numbers and from adequate training who are in a position to render such service. Let me put you a question: what facilities have the osteopaths to offer in the way of hospitalization, specialization, personal service in order that they may carry out health insurance with any degree of success?

The WITNESS: Mr. Chairman, in a small profession such as we are in Canada and under the circumstances which we have tried to show you in this brief, how is it possible to be otherwise than it is? That is why we have to refer to our status in the United States. We have referred to the fact that whether we are practising in Canada or whether we are practising in the United States we are the people that we refer to, fully qualified—not drugless practitioners, Dr. McCann—they choose to call us drugless in Ontario and if they are the majority we cannot prevent them—but what we are appealing for is the permission to render our services. They may be small. Do not forget that the Free French did help in the Tunisian victory. Should they have been eliminated just because they were a small army? They did their share just as efficiently, probably, as any of the other armies, and we can do our share in the fight against disease, I believe, just as effectively as you can. As a matter of fact, our education is identical. Why pick on us and say that we are in another country? You are far closer to many of our colleges in the United States than you are to places in Canada here. You can get all the information you want. We had authority, for instance, in Ontario before the present law was passed, to take medical council examination but even then they were trying to establish that we were an ancillary service. We have tried to prove by this brief that that conception is wrong and false. There is the question of the fact that we have no colleges in Canada and that they are in the United States.

Mr. BREITHAUP: Mr. Chairman, I understood that this was a question period and not a period of further exposition.

The WITNESS: I am trying to answer Dr. McCann who asked two or three questions in one. I was trying to clear up the impression that he has left. I believe I have pretty well finished that.

Mr. McCANN: May I ask this question: is this body in favour of the principle of health insurance without any qualifications, or is it in favour of it only with the qualification that they be accepted on an equal basis with a profession which outnumbers them a thousand to one?

Dr. EGGLESTON: Yes. I should like to ask Dr. McCann if he is asking that we will undertake to treat as many people as the medical profession? The answer is obviously no. If you are asking if we would undertake to treat as many citizens of Canada as the medical profession of Canada the answer is obviously no. In so far as we have been permitted to develop our facilities in Canada, as under your Ontario law here and under the Quebec law, which does not exist, we have developed service to the extent of the ability that has been permitted to us.

Now, Dr. McCann brought up a moment ago the fact that the schools of therapy have developed in the States. I was not aware of any boundary line to science. I am sure that you do not throw radium out of your hospitals because it was discovered by a lady in France.

Mr. McCANN: Let me correct that. I did not object to it on account of it being developed in the United States, that is not the objection at all. I say that all your references or nearly all your references as to what has been accomplished and the laws governing it have been based upon what is taking place in the United States and what has taken place. After all, this health insurance bill is not being framed for the United States. We want to have the information relative to our own country. We as a committee here are making a study of this insurance bill and to conditions that obtain in our own country with reference to the need for health insurance and with reference to those things which can help to carry out insurance.

The CHAIRMAN: What is your question, Dr. McCann? What is your question to the witness?

Mr. MAYHEW: May I ask the witness if the hospitals of Ontario will accept patients from osteopaths?

The WITNESS: The hospitals in Ontario even though they are built by public funds are entirely manned by the medical profession and just as was brought out in a previous answer to a question, there is that same unfortunate attitude that some—I do not like to say—

Mr. MAYHEW: Answer the question yes or no.

The WITNESS: There is a dog-in-the-manger attitude—

Mr. MAYHEW: Will you please answer the question?

The CHAIRMAN: Answer the question yes or no.

The WITNESS: We are not allowed in the hospitals in Ontario, that is, I should say our patients are prevented from getting osteopath service.

The CHAIRMAN: The answer is no.

By Mr. Howden:

Q. May I ask one question? On page 17 of the brief, towards the bottom of the page, you will find this statement: "We would like to assist in clarifying the situation, by stating that it is our belief any attempt to incorporate osteopathy into a medical course must of necessity fail." Now, according to statements of witnesses here today, Mr. Chairman, they approve of the allopathic science of medicine. They say we have done wonderful work; they say their basis of learning and teaching is exactly the same as ours. They acknowledge the use of such things as anti-toxin and insulin for the treatment of disease. In fact, I cannot see very much difference from their statement this morning from our regular practice of medicine. I am wondering how they can justify that statement on page 17, "... that any attempt to incorporate osteopathy into a medical course must of necessity fail." Would you amplify that statement?—A. May I ask Dr. Eggleston to amplify that?

Dr. EGGLESTON: Mr. Chairman, the osteopathic school of medicine only differs from the allopathic school of medicine in concept. The medical schools—I stand to be corrected if I am wrong—have also the same basis upon which therapy is founded, the chemotherapy. Would you say that was the most important thing in allopathic medicine?

Mr. McCANN: No.

Dr. EGGLESTON: May I answer that question by asking one? Would you define the basic conception of allopathic medicine?

The CHAIRMAN: I am sorry, I rule that question out of order. Will you please answer the question?

Dr. EGGLESTON: The only way that that can be answered is clearing up to the lay members of this committee what is meant by basic concept of therapy. The basic concept of therapy is developed from the freshman year through to graduation. The basic concept of medical therapy looks to a different viewpoint in the training and neither school has progressed far enough towards the ultimate truth yet that one can be sacrificed to the other completely.

Mr. McCANN: Mr. Chairman, I did not get a full answer to the question I asked a while ago. Is this organization favourable to the principle of health insurance without any qualifications or do they put in the qualification that they would favour it if the organization is accepted on equal terms with medicine?

The WITNESS: I would say definitely yes provided the public are permitted to receive our contribution not as an ancillary service; that is not our contribution.

Mr. BLANCHETTE: May I ask Dr. DeJardine if Ontario is the only province in Canada where restrictive legislation prevails in connection with osteopathy?

The WITNESS: No, Ontario is not the only province. I believe the surgery that is practised in British Columbia or maybe in Alberta, I am not quite certain, is minor surgery; there is a restriction on major surgery, I believe.

Mr. SHAW: Mr. Chairman, the witness was asked if his organization accepted health insurance unconditionally. I do not consider that was a fair question in so far as no organization has accepted it unconditionally.

Mr. McCANN: You ask your own questions.

Mr. SHAW: You say not only is your organization placed in an inferior position, but you have been faced also with unfair conditions; prejudice and other real barriers have been placed in your way. Would this not therefore be the proper time to give consideration not only to health insurance in particular but to granting justice to various organizations in this country?

The WITNESS: That is exactly what we have had in mind in presenting this brief. We would have much preferred to have said nothing about this intolerance, but unfortunately it is present. You can verify that anywhere, it is all over, and it certainly is not our fault. We tried to make a plea for justice, not only for ourselves but for the patients that rely on osteopathy and those men in the armed services who are entitled to osteopathy. If I may take one second, this problem of the armed services and the air force is one very easy of solution; it is not palatable to organized medicine, but it is simply raising the ranks so that our physician can meet on an equal basis with the medical physician. Then there could be co-operation and friendly competition or rivalry, if you like, and we could be of tremendous service, I can assure you, to the men in the services.

Mr. McCANN: He could not do equal work.

The WITNESS: Not in number, not in quantity, but in quality, we can diagnose anything.

Mr. McCANN: I beg your pardon, not in quality either.

The WITNESS: That is your opinion.

Mr. McCANN: You have not access to those institutions in which that work could be done.

The WITNESS: May I ask why are we not given access to it?

Mr. McCANN: Why?

The WITNESS: Yes.

Mr. McCANN: Because you are restricted by certain legislative bodies. This body has nothing to do with it nor has this parliament.

Mr. FULFORD: Why are these restrictions placed there?

The CHAIRMAN: We cannot discuss this question here.

Mr. LOCKHART: As a member of this special committee sitting here trying to get some intelligent views, may I say we have had briefs presented showing the benefits that physical training has brought, especially in the Soviet Union? I think the witnesses who have answered the questions with regard to a particular scheme of health insurance or social insurance for Canada are quite willing to accept anything that is beneficial in a particular dominion scheme to the health and betterment of our people. I do not think they will object to anything of that nature. They have no objection to anything such as physical training.

The WITNESS: No. Generally speaking I would say yes, provided that this idea of ancillary service does not come into play. If we are given a chance to do what we are fully competent to do why, of course, we are in favour of it. If it can improve the public health we want to be part of it.

The CHAIRMAN: On your behalf I express to the Canadian Osteopathic Association our thanks for the presentation. We adjourn until to-morrow at 12 o'clock, when we shall hear the medical research officials of the National Research Council.

Mr. McCANN: Before we adjourn will you take into consideration the non-holding of meetings during next week on account of the Parliamentary Association having its deliberations each morning next week?

The CHAIRMAN: Thank you, Dr. McCann, that will be considered.

The Committee adjourned at 1.15 to meet to-morrow at 12 o'clock noon.

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Canada Social Security Special
Committee 1943

(SESSION 1943)

(HOUSE OF COMMONS)

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(SPECIAL COMMITTEE)

ON

(SOCIAL SECURITY)

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 22

WEDNESDAY, JUNE 16, 1943

WITNESSES:

Dr. J. B. Collip, Chairman, Medical Research Committee, National Research Council;

Surgeon-Commander C. H. Best;

Dr. Harold Ettinger, Professor of Physiology, Queen's University;

Dr. Duncan Graham, Professor of Medicine, University of Toronto;

Lt.-Colonel W. H. Brown, Army Medical Research.

OTTAWA

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PRINTER TO THE KING'S MOST EXCELLENT MAJESTY

1943



MINUTES OF PROCEEDINGS

WEDNESDAY, June 16, 1943.

The Special Committee on Social Security met this day at 12.00 o'clock, noon. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs.:—Breithaupt, Casselman (*Mrs.*) (*Edmonton East*), Cleaver, Coté, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, Maybank, Mayhew, Shaw, and Veniot.—24.

The Chairman requested Dr. J. B. Collip, Chairman of the Medical Research Committee of the National Research Council, to introduce the other members of that body who were present. They were as follows:—

Surgeon-Commander C. H. Best;

Dr. Harold Ettinger, Professor of Physiology, Queen's University;

Dr. Duncan Graham, Professor of Medicine, University of Toronto;

Lt.-Colonel W. H. Brown, Army Medical Research.

Surgeon-Commander C. H. Best presented a brief and was examined by the Committee, as were also the other delegates.

The Chairman thanked the witnesses who then retired.

The Committee adjourned at 12.30 p.m. to meet again Friday, June 18, at 11.00 o'clock, a.m.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 16, 1943.

The Special Committee on Social Security met this day at 12 o'clock noon. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Order, please; we have the privilege of hearing to-day representatives of the Medical Research Committees of the National Research Council. We have very distinguished representatives, not only of national but international fame. I need not tell what these gentlemen have done in their contributions to human happiness through research. I have the very great honour this morning of calling on Dr. J. B. Collip to introduce Dr. Best and his colleagues.

Dr. COLLIP: Mr. Chairman, members of the committee; the members of the associate committees on medical research of the National Research Council felt so strongly that there should be a continuing of medical research in the post-war era that they appointed a subcommittee under the chairmanship of Dr. Best; secretary, Dr. Ettinger; and Dr. Graham and myself, to draw up a brief to present to you to-day. I have pleasure in calling upon Surgeon-Commander Best to present this brief.

The CHAIRMAN: Dr. Collip, will you please introduce the other members?

Dr. COLLIP: I should like to introduce Dr. Harold Ettinger, professor of physiology, Queen's University; Dr. Duncan Graham, professor of medicine, University of Toronto, and Lt.-Colonel W. H. Brown, army medical research.

Surgeon-Commander C. H. BEST, called.

The WITNESS: Mr. Chairman, ladies and gentlemen: The Associate Committee on Medical Research, of the National Research Council, wishes to lay before the Special Committee on Social Security of the House of Commons, evidence that the National Research Council should be entrusted with the direction of any medical research program which will spring from the application of a national health insurance act.

The past twenty years have been more fruitful in medical research than any other period in the world's history. In Canada, the growth of such research sprang from the discovery of insulin. What this gift has meant to the world is well described in a statement by a large insurance company. "To-day, the average diabetic child of ten may be expected to celebrate his fiftieth birthday, whereas just prior to 1922 most diabetic children lived little more than one year after the onset of their disease. At age thirty expectation of life is now twenty-seven and one-half years, compared to little more than six years in the days before insulin. Even at age fifty the improvement is sizeable, with an expectation of life of fourteen and one-half years to-day which is 50 per cent more than in the pre-insulin era. And these added years of life are useful and active, not years of invalidism. The diabetic of to-day is usually able to take his place in the home and in the community and to lead an almost normal life. The diabetic child goes to school and joins his comrades in study and play. The adult diabetic is a steady and productive worker and competes successfully with his co-workers. Moreover, this great improvement in the active life of the typical diabetic is of particular importance, because the number of these persons in the population is actually increasing through the aging of the population and through the

increased survivals of younger diabetic patients to older ages. The diabetics in the United States and Canada alone number more than one million, and a very large proportion of these require insulin." But Canadians should be grateful for the discovery of insulin also because it has stimulated other young men to investigate the secrets of the mechanisms of life and the treatment of other types of diseases. Canadian discoveries in the hormone and other fields have given Canada a pre-eminent place in medical research.

The Canadian Medical Association, in 1937, passed a resolution petitioning the Committee of the Privy Council for Scientific and Industrial Research to authorize the National Research Council to set up an associate committee for medical research. It also asked for a conference of representatives of interested bodies, viz. faculties of medicine, medical research institutions apart from medical schools, dominion and provincial departments of health, and nationally organized medical associations, i.e. the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada and other bodies. The function of the conference is to nominate to the National Research Council the personnel of the associate committee on medical research, and to outline the scope of its duties and responsibilities.

The conference was held in February, 1938. It recommended that an associate committee be set up under the chairmanship of Sir Frederick Banting, with the following terms of reference:—

(a) To receive suggestions for requirements in respect of medical research, and in matters related thereto.

(b) To consider by whom investigations required can best be carried out, and to make proposals accordingly.

(c) To correlate the information when secured and to make it available to those concerned.

(d) To do such other things as the committee may deem advisable to promote medical research in Canada.

The associate committee was set up within three months. Its members were mainly from the medical faculties of universities, chosen for their proven ability and interest in special fields of medical research, with ample geographical representation. It conducted surveys of medical research facilities in Canada. The interest in research among young medical men amazed even the chairman, Sir Frederick Banting, and plans were laid to embark upon an extensive investigation, particularly of certain chronic diseases.

The committee invited research workers in the different universities and research institutions in Canada to submit problems they were prepared to investigate and to request grants in aid of their research. After reviewing the problems outlined in the applications submitted, based on the nature of the problem, the possibility of solution, the facilities for research and the financial need of the university or institution concerned. All three of these were taken into account. In the expenditure of these funds many young men and women had an opportunity of learning and practising research methods under recognized Canadian investigators. This program had barely started when we entered the war.

The needs of the armed services now took precedence over peace time research. The funds of the associate committee and the work of the young men and women in the laboratories now became diverted to the acute medical problems in relation to the war. Three additional associate committees were created, one to supervise research for each of the armed services. Many medical men who had been employed in laboratories in the universities joined the armed forces and were set at investigating their particular problems. Medical teachers who remained at their posts gave up their peace time researches to investigate war problems, and to direct the work of young men in the services. I may say, ladies and gentlemen, that Professor Graham is chairman of the Aviation

Research Committee, Colonel Brown is chairman of the Army Research Committee and I have the pleasure to direct the activities of the Naval Research Committee.

The research laboratories in Canadian medical schools are now almost entirely engaged in investigation of problems concerning war. Here the researches of the associate committees on naval medical research, aviation medical research and army medical research are under way, partly through activities of young men seconded from the services to these laboratories, and partly through work of civilian investigators. The problems chiefly concern measures to provide comfort, safety, selection of personnel and adaptation to the conditions and implements of modern warfare. The original associate committee on medical research explores fundamental war medical problems which may involve any or all of the services. Professor Collip is chairman of the original associate committee and also chairman of a co-ordinating committee which integrates the actions of the four committees.

Such a program has had two notable results. First, it has meant laying aside the fundamental problems, e.g., in physiology, biochemistry, pharmacology, and in the various fields of clinical research, which would normally engage the personnel of Canadian laboratories and clinics. These are problems which affect the health of Canadians. Their investigations must be postponed, but not abandoned. They are still with us, and they must be explored when the war is over.

Second, it has built up a large and capable medical research organization. The Associate Committee on Medical Research, and the other associate committees dealing with medical research in the services, are integrated through the National Research Council. They are composed mainly of university teachers and research investigators whose services come to the National Research Council without cost. Their membership sometimes overlaps, and that is a very good thing. Most of their work is done in medical laboratories in the universities, where the directors give their time without cost. A large body of young investigators is being built up into efficient units. Important discoveries have been made, many of such a secret nature as to be disclosed to a very few. Some of these discoveries have been so fundamental as to precipitate requests for sharing them with the armed forces of our allies. Through the National Research Council there is frank interchange of ideas with the Medical Research Council of Great Britain, and the National Research Council of the United States. In short, there has never in Canada been such a large and well-trained group of young medical research investigators, well knit together with careful integration of their work. This organization, we feel, should be made permanent.

When the war is over these, and other young people who will be added to them, will be trained and eager to investigate the nation's peace time problems. They will have been brought to this state under the National Research Council. They will be available to the Associate Committee on Medical Research which, as a central organization, will know the Canadian field, and will have had the experience of directing work with economy and productiveness. This committee has had and will continue to have the advice and confidence of all the prominent Canadian medical research workers.

The associate committee feels that at the conclusion of the war there will be an accumulation of medical problems of the civil population, which will be as urgent for them as are the medical problems of the services to-day. A much larger amount of money will be needed for their investigation than was available before the war. They can be most economically and successfully attacked

through the organization which has been built up by the National Research Council, and which has been functioning in these last five years with conspicuous success.

The CHAIRMAN: Thank you, Dr. Best. Are there any questions for Dr. Best?

By Hon. Mr. Mackenzie:

Q. Is it your idea that there should be larger grants for medical research work after the war than before?—A. We have had very much larger grants during the war than were available before, and I think it is quite impossible to carry on at any reasonable rate on the amounts that were available before the war started. They will have to be larger if we are to retain our young men in Canada and carry on as we think we should.

Q. Medical research should be mentioned in the bill as receiving specific grants-in-aid?—A. It has not been mentioned very specifically.

Q. It should be mentioned more specifically?—A. Yes.

By Mr. McCann:

Q. I just want to ask Dr. Best what grants are made now from the National Research Council for medical research, and at the present time are the grants which they receive in wartime met from the war appropriations or from the National Research Council?—A. I cannot say I can answer that in great detail. Perhaps Dr. Collip could do better. I know for the navy there is an appropriation for all types of research made by the government to the Research Council, and part of that is available for naval medical research. It comes as a fairly sizeable amount for physics and chemistry and all naval problems, and they set aside a certain proportion of that which is administered by our Associate Committee on Naval Medical Research. I think perhaps Dr. Graham is in a somewhat similar situation.

Dr. GRAHAM: Yes.

The WITNESS: And Colonel Brown in the army. A very large part of the total activities is now through the service committees and we really are getting as much money as we need. If we have a problem we can get money to investigate it, and that was not true in peacetime.

Hon. Mr. MACKENZIE: Can you give any estimate of the amount you would require in peacetime?

Dr. COLLIP: I think it should be added that the peacetime appropriation was continued for the Associate Committee on Medical Research much reduced and also that most of that money has been spent for war work, but in addition there have been funds from the war appropriation which have further exceeded the peacetime vote in the case of the Associate Committee on Medical Research and, of course, the special committees that have been set up, the Army Medical Research Committee and the Aviation Medical Research Committee and the Naval Research Committee, their funds are almost entirely from the war appropriation.

The CHAIRMAN: Are there any further questions, please?

By the Chairman:

Q. Dr. Best, you mentioned the young investigators doing such brilliant work; how are they financed at the present time, under grants?—A. Well, sir, the civilian ones are financed from the grants which come from the various service committees or from the associate committees; and we also have available a number of keen young men who have seen extensive service, and may I say that they have done a lot of good work. Personally I think it would really be a good thing if their efforts could be integrated with those of the civilians through the research council.

Q. What you desire is to see that done here in Ottawa with adequate funds?—A. If the services will send keen young men to us that will help solve the problem.

Mr. McCANN: There is nothing in the health insurance act to indicate that there would be a likelihood of the discontinuance of medical research, is there?

The WITNESS: I think, sir, we would like to have it made a little more positive than that, and not just left that way.

The CHAIRMAN: It is negative at the present time.

The WITNESS: It is negative at the present time. We think that if you are contemplating spending large sums of money on medical care it would be an extremely good investment to put a certain amount aside for investigations which may make medical care easier and better.

The CHAIRMAN: Your experience has proven that fact all right.

The WITNESS: Yes, I think so.

Mrs. CASSELMAN: Mr. Chairman, at the Victorian Order of Nurses' annual meeting, Commander Best was the speaker and he told us something about what was carried on by the research council and I think everyone present was very much impressed by what he said as to the results they had got through their association. I only wish he had had time to go more into that line.

The CHAIRMAN: Thank you.

The WITNESS: Might I ask the members to read the Forum?

Mrs. CASSELMAN: Yes, they might do that.

The CHAIRMAN: Is that what the radio announcers call a "plug"?

Mr. FULFORD: May I say, Mr. Chairman, that I agree with the suggestion of the minister because first of all Commander Best has presented his brief in such a concise and excellent way, and secondly we are all so much in sympathy with continuing research after the war. I think I am speaking for all the members when I say that we are very much interested in seeing this work carried on, and that we appreciate all that has been done by their organization so far. Personally, I think these research committees should have a chance for carrying on after the war.

The CHAIRMAN: Thank you, Mr. Fulford.

Hon. Mr. MACKENZIE: I am afraid that I am not quite clear on this matter of what it is going to cost to carry on this research work. You indicated the amount that you were getting this year and that it was supplemented by grants from the services. Would you care to indicate this to the committee and what your estimate is for the carrying on of a more extensive program after the war? Can you answer that?

The WITNESS: I think possibly Dr. Collip might give you some information on that.

Dr. J. B. COLLIP: If I may answer your question, sir: in 1939-40 our grant was \$52,965; expenditures on a peace-time basis for that year were \$33,983. Our grant in 1940-41 was \$52,000 of which we expended \$30,000 to \$35,000; and that compares with the war appropriation in 1939-40 of \$10,000; 1940-41 of \$26,000; and 1941-42, \$18,000 and for 1942-43, \$51,000. That is just for the associate committee. The aviation medical committee have a much larger grant than the others, and the army medical—perhaps Lt.-Col. Hurst Brown could tell you about that.

Lt.-Col. BROWN: This year there will be set aside for the purpose of army medical services \$100,000. We do not expect to use up anything like that, at the present time I think we have only expended about \$37,000.

Dr. COLLIP: It is very difficult to think of a figure, but roughly I think we should have a grant of half a million dollars a year and that it could be well spent, if not more.

Mr. McCANN: Are your laboratories for carrying on this work located with the National Research Council up here at Ottawa, or is this work being done in the universities?

The WITNESS: In answer to that question, there has been no central laboratory in Ottawa but rather the work has been done through grants to the universities; although it has been the general opinion among us that it would be wiser, certainly at this stage of our development, to encourage research in the universities all across Canada rather than centralizing in any one place.

Mr. McCANN: On what basis is that distribution made?

The WITNESS: So far, I think, on the number of young men with problems which have to be put up to the central committee; the number of young men available and their interest in research in the various places; and if the problems are good, after being carefully weighed the funds are divided accordingly. But at the present time there are practically no young men available and as we now operate the funds are spread clear across Canada.

Mr. McCANN: Is it your opinion that it would be preferable to establish a central research laboratory here at Ottawa?

The WITNESS: It would be my personal opinion that at this stage of developments it would be wiser to keep it with the universities where they have contact with their teaching hospitals and various other departments of research along very similar lines. I think that would be much wiser.

Dr. COLLIP: I think that speaks for the committee as a whole.

The CHAIRMAN: Are there any further questions?

Well then, Dr. Best, on behalf of the committee I should like to express our sincere thanks to the representatives who have spoken, and especially to Dr. Best for his brief. Thank you very much.

We will adjourn until Friday at 11 o'clock when we will hear representatives from the blind.

The Committee adjourned at 12.30 o'clock p.m. to meet again on Friday, June 18, 1943, at 11 o'clock a.m.

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Canada Social Security, Special
Committee, 1943

(SESSION 1943)

CA1XC2 (HOUSE OF COMMONS

-43871 (SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 23

FRIDAY, JUNE 18, 1943

WITNESSES:

Dr. Jean Gregoire, Deputy Minister of Health, Quebec;
Colonel E. A. Baker, Managing Director, Canadian National Institute
for the Blind;
Mr. Richard Myers, Secretary, National Office of the Institute;
Dr. J. A. MacDonald, National Director for Institute Services;
Dr. Hector Cypriot, member, National Council of the Institute;
Captain M. C. Robinson, Director, Institute Services, Western Canada.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943



MINUTES OF PROCEEDINGS

FRIDAY, June 18, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Casselman (*Mrs.*) (*Edmonton East*), Cleaver, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McGregor, Mayhew, Shaw, Veniot, Warren and Wood.—23.

Colonel E. A. Baker, Managing Director of the Canadian National Institute for the Blind, was called. He introduced the following delegates from that organization:—

Dr. Hector Cypihot, member of the National Council of the Institute, and Superintendent of the Quebec Division of the Institute;

Mrs. Robert Devine, Vice-President of the Ottawa-Carleton Board of the Institute;

W. G. Keddie, member of the Ottawa Board of the Institute, and President of the Ottawa Association for the Blind;

John E. Lavoie, Secretary-Treasurer of the Ottawa Board;

Walter Garlick, member of the Ottawa Board;

Mr. W. E. Hamilton, Field-Secretary, operating in the Ottawa Valley for the Institute;

Mr. Richard Myers, Secretary, National Office of the Institute;

Dr. John A. MacDonald, National Director for Institute Services in Eastern Canada, and Superintendent of the Quebec Division;

Captain M. C. Robinson, Director, Institute Services in Western Canada and Superintendent of the Western Division with Headquarters at Vancouver;

Mr. Harris Turner, Director of Publications for the National Office of the Institute;

Mr. A. V. Weir, General Manager for the National Office of the Institute; and

Mrs. Aurelien Belanger, Eastview, Ont.

Dr. Jean Gregoire, Deputy Minister of Health for the Province of Quebec, was called. He presented a brief, was questioned, and retired.

Col. Baker addressed the Committee.

Mr. Myers presented a brief on behalf of the Canadian National Institute for the Blind.

Dr. MacDonald, Dr. Cypihot and Capt. M. C. Robinson addressed the Committee.

Col. Baker thanked the Committee for the kindly reception of the submission.

The Chairman thanked the witnesses who then retired.

The Brief submitted by the Federation of Catholic Workers of Canada, which was authorized on June 15 to be printed in the evidence, appears as appendix "C" to this day's evidence.

The Committee adjourned at 12.40 p.m. to meet again Tuesday, June 22, at 11 o'clock a.m.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 18, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Ladies and gentlemen, we are here this morning to hear representatives of the blind. Dr. Gregoire, Deputy Minister of Health, province of Quebec, will present a summary of a brief, and Colonel Baker, Managing Director of the Canadian National Institute for the Blind, will introduce the subject, and Mr. Richard Myers, on behalf of the Canadian National Institute for the Blind, will read the brief. Before calling Dr. Gregoire I will ask Colonel Baker to please introduce his colleagues to the committee.

Colonel BAKER: Mr. Chairman, ladies and gentlemen, may I briefly introduce those who are with me to-day representing the Canadian National Institute for the Blind. I shall ask each person as named to stand for just a moment to be recognized: Dr. Hector Cypihot, Montreal, member of the National Council of the Institute and Superintendent of the Quebec Division of the Institute; Mrs. Robert Devine, Vice-President of the Ottawa-Carleton Board of the Institute; W. G. Keddie, member of the Ottawa board of the Institute and President of the Ottawa Association for the Blind; John E. Lavoie, Secretary-Treasurer of the Ottawa board; Walter Garlick (sightless), member of the Ottawa board; Mr. W. E. Hamilton (sightless), Field Secretary, operating in the Ottawa valley for the Institute; Mr. Richard Myers, Secretary, National Office of the Institute; Dr. John A. MacDonald (sightless), National Director for Institute Services in eastern Canada and Superintendent of the Quebec division; Captain M. C. Robinson, National Director, Institute Services in western Canada and Superintendent of the western division with headquarters at Vancouver; Mr. Harris Turner (sightless), Director of Publications for the National Office of the Institute; Mr. A. V. Weir, General Manager for the National Office of the Institute, and Mrs. Aurelien Belanger, Eastview.

That is the group, sir.

The CHAIRMAN: Thank you, Colonel Baker. I shall now ask Dr. Gregoire to come forward.

Dr. GREGOIRE: Mr. Chairman, ladies and gentlemen, in making this report before your committee the Dominion Council of Health wishes to draw your attention to the lack of any treatment or prevention provisions in the present Old Age Pension Act, which simply allows a sum of money monthly to needy persons who are blind.

It is evident, in nearly every case of blindness, that these individuals, because of their affliction, cannot afford medical or surgical treatment.

The Dominion Council of Health, after a study of the whole situation, is convinced that much can be done, by treatment, to make the lot of the blind easier, both by the restoration of sight and by adding to the physical comfort of the individual through treatment.

The Dominion Council of Health is also convinced that the prevention of blindness is largely a public health problem, and concerns maternal and child welfare and school health, as well as the control of all types of infectious diseases, many of which may cause blindness.

The prevention of blindness should also be tied in with the nutritional programs of the various health departments through Canada.

After a thorough study of existing conditions, by a committee of the Dominion Council of Health, the council make the following proposals in respect to new legislation concerning pensions to the civilian blind.

Report of Committee on Civilian Blind to the Dominion Council of Health

1. That the legislation be amended in several matters, together with an extension of the federal-provincial financial agreement, to include items here-under described.

2. That aid to the blind be placed under the jurisdiction of the departments of health, federal and provincial.

3. That the age limit permitting aid to the blind be lowered from forty to twenty-one years.

4. That compulsory registration of blind persons be instituted in all provinces.

5. That the provincial departments of health be empowered to:—

(a) Set up a provincial registry for the blind and partially sighted under a registrar, who is a medical officer on the staff of the health department.

(b) That the registrar be empowered to effect prevention and treatment of the blind or partially sighted through whatever channels or agencies are considered adequate for these purposes by the Minister of Health and his advisers.

(c) That the registrar may grant financial aid to be known as a treatment allowance pending the time an applicant is undergoing treatment, except when hospitalized, to determine whether or not vision may be restored or partially restored.

(d) That the registrar may grant a training allowance for a stated period during the training of an individual where it is believed such training may make him either wholly or partially self-supporting.

(e) That the registrar be instructed to be the integrating and directing force empowered to use all existing public health machinery to bring about the above-named conditions, and to direct the blind or partially sighted towards schools, training and placement in industry, either in workshops or at home, using such agencies as are deemed capable of performing this service.

(f) When treatment or any other form of rehabilitation fails to make an individual self-supporting, the registrar, after assuring himself that the case is one for pension, shall have the applicant examined by the oculist designated by the Department of Pensions and National Health in that area, who shall forward the completed form to the appropriate officer in Ottawa.

(g) The registrar may also absorb the cost of transportation to bring those who are blind from outlying places to treatment or training centres.

6. The division of costs for treatment, training and transportation shall be in the same ratio as for pension.

Committee: Dr. G. F. Amyot, chairman; Dr. Jean Gregoire, member; Dr. C. W. MacMillan, member; Dr. F. S. Burke, secretary.

I shall ask that the complete brief be placed on the record.

The CHAIRMAN: Do you wish to ask Dr. Gregoire any questions?

Mr. KINLEY: Why do they suggest putting the age limit at twenty-one instead of forty for the blind?

Dr. GREGOIRE: Well, I do not see why he should not; there is no reason why he should not get his pension at that age. However, I think that members for the Canadian National Institute for the Blind could answer your question a great deal better than I can, because it is not a question of public health.

THE BLIND IN CANADA

BY

F. S. BURKE, M.D.

Department of Pensions and National Health, Ottawa

The number of known blind in Canada, of all ages, totals 12,344. This number is arrived at through those registered with the Canadian National Institute for the Blind, and those on Pension to the Blind. Apart from these, there is also a very large group comprising those with loss of vision in one eye, or with some progressive type of eye disease, who do not as yet come within the definition of blindness, as stated in the Act, together with some who have not made their condition known, and whose names have not been brought forward for some reason or other. The definition of blindness is contained in paragraph (a) of subsection (1) of section 8A, of the Dominion Old Age Pension Act, and the principles to be applied in determining such conditions are found in regulation 41 of the regulations made pursuant to said Act, as quoted hereunder:—

For the purpose of certifying whether or not a person is “so blind as to be unable to perform any work for which eyesight is essential”, the officers of the Department of Pensions and National Health shall be guided by the following:

- (i) The test is not whether the person is unable to pursue his ordinary occupation or any particular occupation but whether he is too blind to perform every several kind of work for which eyesight is essential;
- (ii) only the visual condition shall be taken into account and other bodily or mental infirmities shall be disregarded;
- (iii) the principal condition to be considered is the visual acuity (i.e., the best direct vision obtainable with each eye separately or both together where both are present, as tested by Snellen’s type using proper refractive lens);
- (iv) persons with visual acuity equal to or less than 6/60 Snellen after correction by using proper refractive lens shall be certified as “so blind as to be unable to perform any work for which eyesight is essential”;
- (v) persons with visual acuity of more than 6/60 Snellen after correction by using proper refractive lens shall not be certified as “so blind as to be unable to perform any work for which eyesight is essential”.

Section 42 of the Regulations reads as follows:

An application for a pension in respect of blindness may be made at any time after the proposed pensioner has reached the age of thirty-nine years and nine months.

In the following table the total number of blind, as shown above, is broken down according to age groups, comparable with those in the Beveridge Report. The greater discrepancies in groups 2, 3, 4 and 5 is probably due to the more stringent definition of blindness used in England, as compared to Canada.

Age group	Number	Percentage of total, Canada	Percentage of total, England (Beveridge report)
1. Under 5 years.....	13	0.105	0.3
2. 5 to 15 years.....	314	2.543	1.9
3. 16 to 39 years.....	1,977	16.015	12.5
4. 40 to 49 years.....	1,441	11.673	10.2
5. 50 to 69 years.....	5,177	41.939	38.8
6. 70 years and over.....	3,422	27.721	36.3
Total.....	12,344*	99.996	100.0

*Males, 7,118; females, 5,226; total, 12,344.

Of those shown above, who are 40 years of age and over, 6,386 are pensioned under the Act and distributed by provinces, as follows:—

Population, 1941 census	Province	Col. 1 Number on pension	Col. 2 Rate per 1,000 population (Pensioners)	Col. 3 Not eligible
453,377	New Brunswick.....	755	1.665	640
93,919	Prince Edward Island.....	113	1.203	33
573,190	Nova Scotia.....	621	1.083	179
3,319,640	Quebec	2,118	0.638	871
3,756,632	Ontario	1,516	0.404	261
722,447	Manitoba	373	0.516	32
887,747	Saskatchewan	320	0.360	37
788,393	Alberta	238	0.302	18
809,203	British Columbia.....	332	0.410	64
<u>11,404,548</u>	Totals	<u>6,386</u>	<u>0.560</u>	<u>2,135</u>

NOTE: The higher ratio of blind per 1,000 population in the eastern provinces may be due to the fact that they are the oldest settled parts of Canada, from which many young people have migrated west, and to the United States.

1. From the above table it will be noted that, as of January 1, 1943, there were 6,386 pensions (Col. 1) representing, at \$240 per annum, a total expenditure for the past year of \$1,532,640, the cost being distributed on the ratio of 75 per cent to 25 per cent between federal and provincial governments.

2. There are also 2,135 (Col. 3) who have applied for pension but found to be "not eligible" because they are not sufficiently blind to qualify. Most of them will qualify within a few years and the group represents a possible further annual expenditure of \$512,400, quite apart from the usual increase. It is among these applicants that treatment would be most beneficial.

The life expectancy of a blind person is rated as normal. The old age pensioners are rated at approximately seven years, but since both are grouped under the Old Age Pensions Act it should be borne in mind that the financial commitment is in nowise similar, because some of our blind pensioners may be on pension for thirty or thirty-five years and as a result every effort should be made to prevent blindness in the first instance, then treat, and cure, as many as possible, together with a careful pre-pension selection.

Those who are familiar with that section of the Old Age Pension Act dealing with blind persons will have noted that there is no provision for treatment or prevention and as a result there are many drawing pension who could be removed from the rolls by adequate treatment.

In order to obtain new information on this phase, a special form was introduced at the beginning of 1942, and completed by the oculist at the time of making his official examination for pension purposes. The results were checked after 534 forms had been received, and the following interesting information was obtained:—

Analysis of treatment recommended by our authorized oculists at the time of examining the last 534 applicants for pensions to the civilian blind in the various provinces of Canada

APPROVED FOR PENSION—356

Number of cases where treatment might restore useful vision..	129 (or 36%)
No treatment recommended.....	227 (or 64%)

NOT YET ELIGIBLE—178

Number of cases where treatment would prevent or delay blindness.....	124 (or 70%)
No treatment recommended.....	54 (or 30%)

It will be seen from the above that 36 per cent of those awarded pension were, at the time of the award, considered curable to the point where useful vision might be restored by treatment.

The table also shows that it is among those not yet eligible that the greatest benefit would be obtained by treatment; 70 per cent of this group could have their blindness delayed or its possibility removed by proper care.

Treatment would consist mainly of cataract operations, but there are also many cases of strabismus, ptosis, pterygium and glaucoma, that also could have useful vision restored. Apart from operative treatment there is a fairly large group needing general treatment for conditions affecting vision, such as diabetes, syphilis, anaemia, malnutrition and avitaminosis, arteriosclerosis and nephritis, etc.

It is realized, of course, that many of those recommended for treatment may refuse to accept. Those indicated by the examining oculist as poor risks are not included in the above.

Observations lead us to believe that malnutrition plays a larger part than formerly thought in the production of blindness. It is among the malnourished that infections of the external parts of eye flourish and become chronic, with resultant scarring of the cornea. Diets high in vitamins will cure these cases but they stay cured only so long as the diet is maintained.

As the large majority of those suffering from progressive diseases of the eye will sooner or later become a charge on the taxpayer, it is evident that the urgent needs at present are prevention and treatment, the latter at no cost to the individual, prevention being largely a matter of public health.

Health Departments are already deeply involved in the prevention of blindness, even though their legislation was not planned primarily for that reason, except in the instance of preventive drops for Ophthalmia Neonatorum. The other endeavours that are preventive in character are—

- Venereal Disease Control,
- Insulin distribution to those unable to pay,
- Prevention and control of Tuberculosis,
- Nutrition measures,
- Control of all types of infectious diseases,
- School medical inspection and the provision of sight-saving classes,
- Accident prevention.

From the above it would seem desirable to place the whole problem of blindness with its prevention and treatment in the hands of the departments of public health where it logically belongs, it being understood, of course, that departments of health would not be expected to maintain treatment centres for this purpose but that they should undertake to direct traffic, probably under some pre-arranged plan of payment, in order that those who could be helped by treatment do not go without because of technicalities and eventually become a total charge on the State.

Another point worthy of consideration is that in many instances those applying for pension have suffered a gradual loss of vision over a period of years, with a corresponding loss of earning power and a resultant lowering of the standard of living, even to the point of absolute want, which in itself must adversely affect the nutrition of the eye as an organ.

Causes of blindness among pensioners are difficult and intricate to compile because we are endowed with two eyes which seem prone to become affected with different conditions.

¹Marshall and Seiler (Glasgow) in their study of the causes of blindness, as reviewed on Page 518 of the *Lancet* of October 31, 1942, are quoted as follows:

"In assessing the importance of different causes it was found that a different result was obtained if the second eye was taken as the cause of blindness than if the first was chosen. The results published are on the basis of the second eye, and thus if one eye is blind from myopia and the second eye is blinded by injury that person's blindness is classified under injury".

This is undoubtedly one way out of the difficulty and makes a statistical summary possible, but it still leaves us lacking in certain information, indicating the original condition which started the train of events towards blindness. Our experience indicates that those losing one eye for any reason seem prone to have trouble eventually with the second eye.

Apart from bilateral cataract, optic atrophy and glaucoma, the causes of blindness are extremely varied, and among the pensioners in one of the provinces, the chief pathological reasons for granting pension are—cataract, optic atrophy, glaucoma, myopia, retinitis and corneal scars, together with a great variety of mixed conditions. There are also more hereditary eye conditions than one would expect. Cataract holds the greatest possibility for restoration of sight, by operative measures, but many other conditions respond to general treatment, to some extent. A great deal of damage appears to have been done by unchecked infections of various types, aided by poverty and ignorance of the outcome.

The present legislation in respect to pensions to the blind civilians is administered by the federal Department of Finance, under an amendment to the Old Age Pensions Act, and blind pensions are administered provincially through the Old Age Pension Commissioner Boards. It will be noted that while blindness is in every case a pathological condition the Act is controlled by non-medical Departments. The Department of Pensions and National Health is charged only with the responsibility of assessing the degree of blindness and ruling whether or not the applicant comes within the provisions of the Act.

At the present time there is no arrangement whereby the provincial Old Age Pension authority may provide treatment to restore sight where it is thought possible by the oculist, or to apply treatment for those with failing vision and who may become a total charge on the State if left untreated.

²The United States have a variety of ways of helping the blind and ten states have even gone to the extent of legislating that those who refuse reasonable treatment to restore sight shall be denied aid. This is not the rule, however, and it is generally felt that the well-trained social service nurse or social service worker can bring about treatment where there is a reasonable chance of success. Certain states report substantial sums of money saved through the establishment of adequate treatment facilities and they are equally enthusiastic concerning the prevention of blindness in that group who are not yet eligible for pension. They have proved beyond doubt that a large measure of blindness can be prevented, and a portion of those already blind can be made to see.

The Act limits the payment of pensions to blind persons who have reached the age of forty years. It is difficult to understand why a young adult on the threshold of life and blind, is of less consequence than a man of forty. The young person, with the aid of treatment or training, may become self-supporting, while our experience leads us to believe that if nothing is attempted until the blind are past middle life very little can be done from the standpoint of rehabilitation, largely because of lost initiative and vigour. Pensions should be linked with treatment and training and given only when the other two fail,

and the age limit should be lowered to twenty-one years or even lower, considering that the blind or partially sighted have either a nil or greatly reduced earning capacity, until trained.

Among the 1,631 registered blind between the ages of 20 and 40 years, their employability, as provided by the Canadian National Institute for the Blind, is as follows:—

Blind males, employed.....	400
“ “ partially employed	468
“ “ unemployable.	153
Blind females, single, employed.....	150
“ “ “ partially employed	230
“ “ “ unemployable.	67
Blind females, married, employed.....	15
“ “ “ partially employed	124
“ “ “ unemployable.	24
Total.....	1,631

Unemployable groups includes—

Unemployable, mental	142
“ other.	102

Total unemployables..... 244

It will be noted from the above table the high employability of the blind between the ages of 20 and 40, there being only 244 incapable of earning, and who could be pensioned at the small cost of \$58,000 per annum, although it might be well to consider subsidizing the partially employed, to bring their earnings to the level of full pension.

Much is now understood concerning the causes, prevention and treatment of blindness. It only remains to integrate and apply this knowledge under the proper department of government.

Years of experience have taught us what extraordinary things the blind can accomplish in almost any walk of life, given a little encouragement and opportunity. Let us not open the door grudgingly, but throw it wide.

REFERENCES—

¹Marshall, J. and Seiler, H. E.,
British Journal of Ophthalmology 26.

²Sight-Saving Review Supplement.
Vol. XII, No. 1.

Thanks are due to—

Canadian National Institute for the Blind
for statistical information.

COST—*Accumulated 40 years and up. Six years' accumulation of untreated pensioners and not eligible applicants.*

1. It is estimated that 25 per cent of the present pensioners would profit by treatment, to the extent of having a measure of vision restored.
1597 pensioners at \$100.00..... \$ 159,700 00
2. It is estimated that 70 per cent of the not eligible applicants might have blindness prevented or delayed by treatment, thus removing them as potential pensioners.
1494 persons at \$100.00..... 149,400 00

3. It is estimated that 50 per cent of those not eligible for pension might, after treatment, be trained to be self-supporting.
 1068 persons for six months at pension rate (\$120.00) 128,160 00

Total \$ 437,260 00

The above total would not be an annual or recurring cost, and against the amount there would be a number who would be eliminated from the present pension rolls (Item 1) and a large group who would not become pensioners. (Item 2).

It is not believed that sufficient specialized medical services exist in Canada to immediately undertake the correction of the disabilities indicated in Items 1 and 2. It would likely take several years to cover the whole group and the cost would be in proportion to the amount done each year. It is not believed that arrangements could be made to spend in excess of \$200,000.00 per annum.

The argument in favour of treatment is supported by the fact that if only 10 per cent of the present pensioners were removed from the lists by treatment, for a period of ten years, the saving in pension would be one and a half million dollars..... \$1,500,000 00

Increased Annual Cost

The increased annual cost, over and above the present amount paid to pensioners, is estimated as follows, and includes a new group from twenty-one to thirty-nine years of age.

1. (*Forty years and over*)

Treatment for 25 per cent of average annual eligible (at \$100.00)	\$ 20,000 00
Treatment for 70 per cent of average annual not eligibles (at \$100.00)	26,000 00
Training for 50 per cent of average annual not eligibles at 6 months' pension rate....	22,000 00
2. (*New Group—Under forty years*)

21 - 39 age group—unemployable (full pension rate)	58,000 00
21 - 39 age group—partially employable (half pension rate)	98,000 00
Training and treatment for an unknown group under forty years of age, estimated at an annual discovery rate of 200, and treated or trained at an equivalent of six months' pension cost	24,000 00
Transportation is difficult to assess but it is suggested that from three to five thousand dollars per Province, annually, would cover the cost.	
Total estimate.....	30,000 00

Total..... \$ 278,000 00

Cost of Pensions at present time

Total pensioners, 6386, rate \$240.00 per annum,	
25 per cent payable by Provinces.....	\$ 383,160 00
75 per cent payable by Federal Government	1,149,480 00
<hr/>	<hr/>
100 per cent	\$1,532,640 00

Applications for aid to the Blind have been falling off since the beginning of the War, presumably due to better labour conditions—

Average of past 3 years	Per annum
Pensions awarded	793
Applicants found not eligible	369
<hr/>	<hr/>
Total applications	1162

Colonel BAKER: Mr. Chairman, ladies and gentlemen, I intend to be very brief in introducing our submission to you this morning. For twenty-five years we have been working shoulder to shoulder in the establishment and development of services for the blind across Canada. This is a co-operative movement with those who have lost their sight in war services, and those who still, fortunately, have their sight, public spirited men and women, working together across the whole of Canada.

I introduced to you earlier members of the local board of the institute and a member of our national council, Dr. Cypihot. We have on our national council, on divisional boards, and on 100 local boards and committees across Canada, representatives such as these who are working conscientiously for a solution of the problem involved for the blind and for the improvement of their living and welfare standard. Now, it is true that when we were before a parliamentary committee of the House of Commons some eight years ago we undertook to place before you at that time a comprehensive outline of our services and our efforts, and at that time we asked the dominion government to consider pensions for the blind. I indicated that if pensions were granted our institute would be encouraged and to some extent relieved of expenses with respect to those who are aged or so incapacitated that they could not work, and that we, the institute, would undertake to broaden and intensify our employment services and our prevention of blindness work. You now have a presentation from the Dominion Council of Health indicating that in the meantime our efforts in the direction of the prevention of blindness and our health efforts across Canada have borne fruits, because we have a very splendid presentation from the Dominion Council of Health.

Then, from the standpoint of employment, we believe that it is not only desirable but most humane to prevent blindness, but if blindness cannot be prevented then to make every employable blind person self-supporting. To that end we have, since our presentation to you eight years ago more than doubled the employment of the blind across this country. We are still not satisfied that we are doing a sufficiently thorough job. We are at the present time in the process of making a thorough check of all our registered blind people to see if there are still others who, being unemployed or partially unemployed at the present time, may be re-trained or assisted to find a fuller measure of employment to the end that they may be fully self-supporting.

And so, may I simply and very briefly stress what is to our minds a most important object—from your point of view and from ours as well as for the blind—and that is the fullest possible development of employment opportunities. It is important to the blind because it enables them to be independently self-supporting; it is important to us because it affords not only encouragement to

us but also encouragement to other blind people; it is important to the country because it means that every blind person that can be made self-supporting leaves funds free for other necessary purposes.

I am not going to take more of your time at this moment. With your permission, sir, I will now call on Mr. Richard Myers to present our brief.

The CHAIRMAN: Before we call on Mr. Myers, will you endeavour to answer the question asked by Mr. Kinley with regard to the age limit?

Colonel BAKER: Yes, sir. With regard to the age limit we find in the age group between twenty-one and forty the highest incidence of employability; at the same time we find in that group people who, by reason of multiple physical disabilities in addition to blindness, are definitely and permanently unemployable, and it is for them that we are primarily concerned in the extension in the age limit down to twenty-one.

The CHAIRMAN: Thank you, Colonel Baker. Mr. Richard Myers will now read the brief on behalf of the Canadian National Institute for the Blind.

Mr. RICHARD MYERS, called.

The WITNESS:

AID TO THE BLIND OF CANADA

STATEMENT

BY

THE CANADIAN NATIONAL INSTITUTE FOR THE BLIND

TO

SPECIAL COMMITTEE ON SOCIAL SECURITY

HOUSE OF COMMONS SESSION 1943

Introductory Remarks

Appropriate and justifiable aid to the blind of Canada is the object foremost in the minds of all who have been interested in and have been working for this worthy cause. Twenty-five years ago the comprehensive services of The Canadian National Institute for the Blind were inaugurated on a dominion-wide basis. Registration, home teaching and vocational training, employment and a variety of ameliorative services were started and have been developed broadly.

In 1924 those interested in the work of the institute began to realize that vocational and employment services could not solve the problems of the aged or other blind persons with multiple disabilities, hence the conclusion that State allowances or pensions for such should be sought. In 1933 a general petition for pensions for the blind, signed by all branches of the institute and co-operating organizations, was presented to the government. In 1935 representations by the institute and local organizations of the blind were made to the parliamentary committee. At that time preference for a special blind persons' act was expressed but in order to avoid complications and delay it was agreed that an amendment to the Old Age Pensions Act should be supported.

In 1937 following further negotiations, the government introduced an amendment to the Old Age Pensions Act providing pensions for the blind on and after the age of 40 and following passage this became effective in and after the autumn of that year subject to provincial agreements.

The Canadian National Institute for the Blind through its registration of the blind and contact with ophthalmologists throughout the country was able to render extensive co-operation to provincial administrative bodies and to the departments of finance and pensions and health of the dominion government.

The welfare of blind persons, especially those in the unemployable and semi-employable groups, has been vastly improved as a result of provision made. For this improvement the blind affected and all interested in their well-being are most appreciative.

Six years have now elapsed since the enactment of this legislation. During this period blind persons eligible have been granted pension while the institute and government departments concerned have studied the extent to which the provisions are adequate and appropriate as well as the extent to which a more effective treatment and prevention of blindness program might improve the lot of those who would otherwise come within the pensionable group. The Institute has reached practical conclusions which will be set forth in order in this presentation. All concerned are deeply gratified that the Dominion Council of Health, representing as it does, dominion and provincial departments of health, has become interested and impressed by the possibilities of prevention of blindness and the practical improvements in the basis of aid to the blind to the point where they have made a most important presentation to this committee. While we are not wholly clear as to the nature of the practical application of some items affecting the blind, we fully agree with the principles involved and the object in view. We are particularly interested in the items providing for treatment for the conservation and restoration of vision.

At the inception of its work the program of The Canadian National Institute for the Blind was broadened to include the important object, prevention of blindness. To March 31, 1943 the institute had served 30,055 prevention cases. In the year ending March 31, 1943 the number of prevention cases served was 2,452. Of these 1,755 were new cases. In the same year the number of newly blind cases registered was 949. The number of blind cases served in the same year, however, was 10,867 out of a total registry of 12,546. These figures are presented for the purpose of emphasizing not only how important the institute considers prevention work to be also for the purpose of making it clear that the institute's opinion in this matter is based upon wide experience. Many cases of prevention have been assisted indirectly by the institute and are not included in the above figures because the expense incurred was carried by service clubs, voluntary organizations, hospitals and ophthalmologists. The institute has been obliged, owing to limitations of financial resources, to restrict its prevention cases as follows:

- (a) Children possessing 6/24 or less except for myopics and squints.
- (b) Adults possessing 6/36 or less.
- (c) Cases of eye injuries, serious infections or other conditions recommended by consultant ophthalmologists for special attention.

In developing the institute prevention of blindness program we have enjoyed the co-operation of provincial department of health, health nurses, educational authorities including school nurses and teachers, welfare and service organizations, especially women's institutes and other women's organizations in rural districts. Finally members of the medical profession and especially ophthalmologists throughout the whole of Canada have taken the keenest interest and have cooperated in a way that has made results thus far achieved possible. The Institute has, we believe, demonstrated the need and possibilities of a more comprehensive prevention of blindness service in the interests of people who are threatened with the loss of sight or serious impairment of vision. We insist that for humane and economic reasons it is more logical to prevent a serious and handicapping disability than to calmly stand by and attempt to mitigate difficulties after the damage has been done. We welcome any progressive development which may help to safeguard the vision of the people of Canada. For this reason we desire to place on record our appreciation and support of the recent recommendations of the Dominion Council of

Health. We, of course, recognize that these recommendations are mainly designed to benefit adults. This is an important section of the field. However, we hope to see the day when the other and possibly even more important section of the field, i.e. the youth and the children, are more definitely provided for. Our reason for feeling that this portion of the field may be even more important is that many of the visual impairments affecting adults had their inception in early childhood or youth and unchecked have been, in many cases, progressing more or less rapidly throughout the years. Certainly the Institute eye treatment and prevention of blindness program, if partially relieved of pressure in the adult field, will be able to function more comprehensively in the earlier age groups.

To provide a clear picture for the consideration of both services to the blind and the prevention of blindness, we are tabling for the information of the committee, first, Age Classification—Blind Persons in Canada (C.N.I.B.) November 30, 1942; and second, Classification of Causes of Blindness (C.N.I.B.) based on 6,445 cases of registered blind for whom up-to-date and adequate ophthalmological diagnoses are available.

In that connection I have tabled with the clerk of the committee those submissions which I hope will be incorporated in the complete record.

The CHAIRMAN: Yes, Mr. Myers, they will be incorporated in the record.

(Statement on "Age Classification" appears as Appendix "A". Statement on "Causes of Blindness" appears as Appendix "B".)

The WITNESS: These tabulations are important since they cover blind persons from the youngest to the eldest resident in all parts of Canada and indicate not only the distribution in age groups but as well the great variety of conditions leading to blindness. The classification of causes of blindness also indicates the substantial number of persons whose loss of sight was due to conditions which could have been cured or alleviated by early attention, prompt diagnosis and proper treatment, thus preventing blindness.

The recommendation of the Dominion Council of Health that a treatment allowance should as well be provided for persons incapacitated by an eye condition requiring a waiting period before a successful operation could be performed or extended treatment, is, in our opinion, a practical measure. This would afford assistance in the subsistence problem pending determination of the outcome of treatment while avoiding disturbance incident to the stoppage of a pension that had already been granted.

Recommendations

1. That all legislation providing aid to the blind and prevention of blindness should be embodied in one act.
2. That blind persons on pension be encouraged to increase their earnings by partial deduction from pension for amounts earned in excess of present permissible maxima.
3. That all blind persons possessing visual acuity of 3/60 Snellen's Chart, or less, shall be granted a guiding and special assistance allowance of \$10 per month.
4. That the age at which applicants may be eligible for aid to the blind should be 21 years.
5. That the rate of pension should be increased and tied to the cost of living subject to periodic adjustments.
6. That for persons who have entered Canada with good vision and who through a serious illness or non-compensable accident have lost their sight, resident qualifications be reduced to five years.

Separate Act

The experience of The Canadian National Institute for the Blind, in the twenty-five years that it has been serving the blind people of Canada and especially in the six years that have elapsed since the Old Age Pensions Act was amended to include pensions for the blind, has convinced us that all welfare legislation affecting the blind or the prevention of blindness ought to be contained in a single act separate and distinct from all other legislation. The submission of the Dominion Council of Health to this Committee seems to us to pre-suppose such an act and if the Council's recommendations, together with those included herein, are accepted, a separate act becomes imperative.

A Sliding Scale for Pensions

Under the present urge for increased production there is no need to argue that society benefits by keeping individuals at work. If the blind person is on pension, he may, if he is single, earn \$200 additional each year to his pension of \$240, giving him an income of \$440 a year. If he is married he may earn \$565 in addition to his pension of \$240, giving him an income of \$805 a year. If earnings exceed these respective amounts the blind person gets no benefit whatever until his earnings have exceeded an additional \$240. Furthermore before his pension will be restored a sufficient period of time must elapse to make the income for the single man average \$440 a year and the married man \$805 a year.

The effect of these regulations is to prevent blind persons on pension from increasing their earnings, first, because earnings must increase by such a large amount before the blind person receives any additional benefit, and second, because such a long period of time must elapse before he may have his pension restored. A similar phenomenon came to light in 1942 in the income tax law of that year whereby persons in certain income brackets were deprived of any benefit from increased earnings until the increase was substantial. The net effect was that many persons worked only so long as their income netted them some additional return. This anomaly was removed in the budget of 1943 by which removal tacit acknowledgment was made of the principle that people are reluctant to increase earnings when they receive no benefit whatever from the increase.

To remedy these circumstances that under present legislation penalizes a blind person on pension for increasing his earnings and thereby increasing the welfare of the nation, it is proposed that any blind person on pension should be permitted to exceed the present maximum (\$440 a year for a single man and \$805 for a married man) provided that pensions are reduced by an amount not in excess of 50 per cent of the additional earnings. If this policy were followed pensions to a single blind person would cease when his net income reached the rate of \$680 a year and to a married blind person when his net income reached the rate of \$1,045 a year. It is further proposed that these pensionable blind persons should not lose their eligibility for pension but that when their incomes fall below the rate of \$680 and \$1,045 respectively, pension should be restored on the reverse scale to that on which it was reduced.

It is perhaps worth emphasizing that this discussion of a sliding scale for pensions deals with the *rates* of earnings rather than absolute yearly earnings. In other words a blind person who has been taken off pension because his rate of earnings was in excess of \$680 for a single person and \$1,045 for a married person will be automatically restored to pension. As soon as his earnings fall below the aforementioned rates, the absolute amount of his earnings during the period he was not on pension would have no relation whatever to restoration of pension.

Attached hereto are schedules "A" and "B" illustrating variations in earnings and pensions on the sliding scale proposed.

The sliding scale of pensions would have many advantages in the effort to make a larger number of blind persons self-supporting. Since blind persons on pensions are employable only within a very limited range of occupations, work in these occupations is not always available and not always continuous but if the blind person were permitted to undertake the work without jeopardizing his eligibility for pensions he could often be made self-supporting without the aid of pensions and more often would be able to improve his own position and at the same time release the tax payer of part of the cost of his pension.

The institute has had the experience of blind persons who had been considered unemployable but who, after many experiments showed themselves capable of performing well certain industrial operations. If pensions were provided on a sliding scale experiments with such persons could proceed uninterrupted until it had been clearly established they were unemployable or until a satisfactory occupation was found for them. Under present regulations these persons and any organization attempting to serve them, are discouraged from making persistent efforts to increase their total income.

Under present regulations there is a wide gap between the upper income limits for persons on pension and the point at which they can become self-supporting without the aid of pensions. Our proposal of providing pensions on a sliding scale helps to bridge that gap and to make possible the gradual transition from the status of pensioner to the status of independent self-supporting citizen.

An Alternative Proposal

We recognize that some time would elapse before present legislation could be amended to make effective the proposal that pensions should be reduced on a sliding scale as earnings increase. It is also recognized that some administrative problems would have to be settled before the system could be put into effect. At the present time, however, The Canadian National Institute for the Blind could provide additional employment for some persons on pension but the duration of such employment is uncertain and the limitations placed upon earnings of blind persons on pension are so restricted and the circumstances affecting the time that must elapse before pensions could be restored are so troublesome that both the blind persons themselves and the Institute are reluctant to take the step of removing any blind person from the pension list unless there is very strong certainty that that person can be continuously and successfully employed. To effect something that may be enacted expeditiously the upper limit to which blind persons may earn without incurring loss of pension, could be placed at the figure between which the government gives complete exemption from income tax, namely, \$660 for a single person and \$1,200 for a married person. Presumably these lower limits have been fixed on the assumption that a single person at work requires \$660 a year undiminished to maintain himself and that a married person required \$1,200 to maintain a family of two. We do not suggest that this alternative proposal is as basically sound as the proposal made above and it would be more costly to the tax payer, but we feel justified in putting it forward in the light of the present need for labour with a feeling that it presents no administrative difficulties. It could be enacted without delay and we have used the figures adopted in fixing minima for income tax because they already have recognition in legislation passed by Parliament.

Guiding Allowance

Blind persons in comparable walks of life to that of sighted persons are faced with increased costs, not in the actual process of doing their work but in getting to and from work and in the general routine of daily living. We feel that it is justifiable that this circumstance should be taken into account and that a guidance allowance should be provided. Before a parliamentary committee on February 21, 1935, we made the following observations:

An analysis of records of any group of blind persons reveals three obvious classifications:—

1. Those who have lost both eyes or have suffered total loss of sight in both eyes.

2. Those who still possess some sight varying from the merest perception of light in one or both eyes to those who can see large objects (specified by Ophthalmologists as approximating 3/60 Snellen's Chart).

3. Those who see large objects from one or both eyes to those who possess fair guiding vision, i.e., can barely read one-quarter inch block type at one foot distance with the better eye including any possible correction with glasses (Ophthalmologists' test 6/60 Snellen's Chart).

Our experience since 1935 and particularly since the introduction of pensions for the blind, has confirmed the above observations and on the basis of that experience we make the following specific proposal:

1. That all blind persons possessing visual acuity of 3/60 Snellen's Chart, or less, shall be granted a guiding and special assistance allowance of \$10 per month.

2. That this allowance should not be computed as income for purposes of pensions for the blind or for purposes of income tax.

Reduction of Age Limit to 21

We are further of the opinion that the pensionable age for blind persons should be reduced to 21 years. The Dominion Council of Health in its submission to this committee recommended the lowering of the age limit to 21 for those incapable of gainful occupation and this recommendation of the Dominion Council of Health is in close agreement with a similar suggestion made by the Canadian National Institute for the Blind before the parliamentary committee in 1935 when the committee was urged to give sympathetic consideration to making pensions applicable to blind persons not capable of engaging in gainful occupations but who were in the age group between 21 and 40.

In making this recommendation that the age limit for pension should be lowered to 21 it ought to be emphasized that we consider that pension should be applicable to all blind persons unless they are being provided with training allowances or sustaining allowance while undergoing treatment. If this recommendation is accepted, together with the recommendation that pensions should be reducible on a sliding scale as earnings increase, all the adult blind would be fully protected on the scale provided and yet there would be no deterrent to blind persons accepting work and earning all that their ability and social conditions permit. The net effect would be that pensions would be received only by those who were either incapable of engaging in gainful occupation for physical or social reasons and those whose circumstances did not permit them to engage in full-time occupation. It is undesirable that pensions should be made applicable in such a manner as to penalize anyone for adding to his income or for circumstances that cannot always be covered by medical treatment or training allowances.

Pension Rate Adjusted to Cost of Living

It is becoming more and more widely recognized that any payments given to cover basic needs ought to be related to changes in the cost of living. The Canadian National Institute for the Blind is strongly of the opinion that whatever the basic rate for pensions for the blind may be, that rate ought to be adjusted from time to time in accordance with the movement of the cost of living. The unfortunate circumstances that attend a person whose income is both small and fixed when prices are rising, have recently been recognized by the Dominion Government by its granting additional amounts under the War Veterans' Allowance Act and by various provinces by increasing the amount paid for old age and blind pensions. Of course the principle has been

widely adopted throughout Canada with respect to wage rates. If the principle is equitable with respect to wages it must be considered essential with respect to pensions for the blind where the rate is so very much lower than what is recognized as necessary for a minimum standard of living.

Basic Rates

There has been much discussion and not a little dissatisfaction over the basic pension of \$20 a month for blind and old age pensioners. This has been accentuated by the rising cost of living and, as already mentioned, several provinces have taken steps to increase the pension rate. In other presentations to this committee the whole question of basic minimum rates has been raised and we feel it would be untimely for us to make a special representation on this particular point for the blind until the broader question of social security has been thoroughly analyzed. We have noted with interest the proposal in the Marsh report that these rates should be \$30 for a single person and \$45 for a married person. We do feel, however, that we are justified in asking that basic rates for the blind should be tied to the cost of living and that should the committee recommend higher basic rates and should the government accept that recommendation, all the figures we have used in this memorandum to illustrate the principle underlying our recommendations should be adjusted accordingly.

Residence Qualifications

Under existing legislation a blind person must be resident in Canada twenty years before he is eligible for pensions. Owing to the extreme handicap that blindness imposes upon a person it is proposed that the period of residence should be reduced to five years or until a person obtains citizenship. If health regulations covering immigrants to Canada are not such as to preclude those who are blind or suffering from diseases of the eye which might result in blindness the treasury could be protected by making pensions under the shorter residence period permissible only to those whose blindness resulted from non-compensable accident incurred or disease contracted after arrival in Canada. Such a provision would help to remove some of the tragedy of blindness which bears exceedingly heavily upon new Canadians.

Employment and Training

The employment of blind persons in Canada has been greatly extended, especially in recent years. In our submission to the parliamentary committee, February, 1935, we presented employment statistics showing the numbers of blind persons employed in a variety of occupations. Institute employment in broom, basket, wood working, and whitewear factories, stands of all types, staff, etc., was 400 in 1935 and 806 in 1943. The number of Institute home workers increased from 623 in 1935 to 1,254 in 1943. Blind workers placed by the institute in general industry and business employment were 24 in 1935 and 125 in 1943. Blind workers on the staffs of schools for the blind and employed by local organizations for the blind in Montreal were 164 in 1935 and according to the latest information appears to be substantially the same at this time. Finally with the information available in 1935 blind persons employed as piano tuners, organists and teachers of music, osteopaths, chiropractors, masseurs, salesman, etc., was 265, but with more complete information in 1943 this group numbers 458.

It is interesting to note that the earnings of Institute blind employees have increased from \$400,000.00 in 1935 to \$925,000.00 for the year ending March 31, 1943. These earnings do not include the 125 blind workers placed and supervised by the institute in general industry whose earnings are estimated at \$125,000.00, also the 458 piano tuners, salesmen, etc., assisted by the institute in a variety of ways and whose earnings are estimated at \$200,000.00.

These figures are in themselves eloquent testimony of the success that has been achieved in the past eight years and belie the fears that were expressed when pensions for the blind were granted, that pensions would deter blind persons from seeking gainful occupation. The great obstacle to the employment of blind persons has been the result of the understandable prejudice on the part of employers. The work of the institute and the success achieved by blind workers who have been placed in employment through the efforts of the institute are gradually dispelling this prejudice.

The increase in the demand for labour as a result of Canada's war effort has during the past three years also been a contributing factor. Hence the long range employment policy and efforts of the institute coupled with education of employers and demonstrations of ability by blind workers is steadily producing increasing interest and confidence in the employment of the blind. This confidence is in turn helping to open new opportunities for the industrial placement of specially selected and carefully located blind workers. We are determined to press forward with the work of placing the largest possible number of blind persons in industries outside of the shelter of the institute while at the same time keeping our specialized industries, workshops, business and services at the highest point of efficiency. We are confident we shall receive increasing co-operation from industrialists as knowledge of what the blind can do becomes better known. Since the passage of the Blind Workmen's Compensation Act, (Ontario 1931) no blind worker employed in industry outside of The Canadian National Institute for the Blind and who at the same time was subject to the provisions of the Act has incurred an accident involving loss of time chargeable to the consolidated revenue account of the province of Ontario.

Working upon experience that the institute has gathered in the past twenty-five years a program has been inaugurated whereby it is confidently expected that the range of employment for blind persons will be greatly extended. Steps have already been taken to adapt vocational guidance tests to meet the needs of the blind, to inaugurate the system of job analysis and to greatly strengthen and extend the supervisory service for blind persons in employment. In this work we are enlisting the guidance and service of Canadians who are most outstanding in the field of vocational guidance, job analysis, personnel management, management engineering and sociology.

The work of the institute, although it is primarily concerned with the blind, is of extreme importance for the handicapped generally. The demonstration that there are occupations that can be filled by the blind equally as well as by the sighted has carried with it the implication that there are occupations that can be filled by other handicapped persons equally as well as by the physically fit. We have gone even farther than that in our own workshops and offices. For certain occupations requiring sight we have employed persons with handicaps other than blindness and we have demonstrated that in ever so many instances these persons are capable of doing effective work on a competitive basis. We are gratified by the recognition that has been given to our work through the widespread interest in handicapped persons and through the progressive outlook on the part of other social organizations and by our dominion and provincial governments.

We agree with the principle underlying the recommendations made by the Dominion Council of Health that allowances be granted for the training of the visually handicapped but we feel that we should call to the committee's attention some practical precautions which should be observed.

1. Training allowances would have to be administered by departments of government in the nine provinces of Canada. It may be difficult to have procedure standardized to make these uniform throughout the Dominion. In the absence of uniformity, confusion resulting probably in much hardship, may develop.

2. There is a danger that categories of employable, partially employable and unemployable may be rigidly fixed or that persons classified as belonging to one or other of these categories may find it difficult to have their status altered. The employability of handicapped persons generally and of blind persons in particular depends upon a variety of factors: natural aptitude, physical condition, training, environment and the presence or absence of employment possibilities within the limited range of occupations that can be effectively mastered by such persons. The institute's experience has been such as to make it reluctant to say with any degree of positiveness that a given blind person is unemployable until it has very exhaustively studied the case and frequently until it has experimented by practical tests with the individual whose case is under review.

3. There is also a danger that in some provinces the determination of whether or not a blind person is employable may be entrusted to those who are not authorities on employability or at least the employability of blind persons. Graduates of schools for the blind are usually ready for employment as soon as they leave school and the institute generally has been able to place these graduates with little delay or difficulty. The problem is more complex for those who lose their sight in adult life. Some are extremely adaptable, make their adjustments quickly and can be placed at work in a relatively short while, receiving most of their training on the job. Others make their adjustments more slowly, requiring more training and can be placed only with difficulty and sometimes often a considerable amount of experimentation. Still others, owing to age and other disablements, are not suitable to be trained either for employment by the institute or in outside industry. The institute does some of its training when the blind person is at work, some of it at a divisional centre and some of it in the home. Those who are not capable of working away from home are taught handicrafts by the home teaching staff of the institute. Each year an average of over 300 newly registered blind cases are given instruction in their homes.

It is desired to emphasize that none of these categories are definitely fixed. Repeatedly it has been our experience that persons have changed their status from unemployable to partially employable, to fully employable and sometimes in the reverse order. Because of nation-wide services rendered by the Canadian National Institute for the Blind much of the actual training under any scheme would have to be done by it, and in the interest of the public and of the blind it wishes to guard against the possibility of having potentially capable persons placed in the unemployable group and on the other hand of having its training facilities overcrowded by large numbers of trainees whose potentialities are extremely low.

Concluding Remarks

With every advance in social provisions whereby basic and fundamental needs of the blind have been outlined or provided for by ameliorative legislation the institute has been able to broaden its services. The National Council of the institute which is directly responsible for the development of service policies and facilities has been strongly imbued with this principle and deeply concerned with not only the welfare of the blind in general but as well the practical rehabilitation possibilities of all sightless people who may be fully or partially employable. In developing and applying these service policies the council has the active and whole-hearted co-operation of institute divisional boards in eastern and western Canada, together with over one hundred district boards and committees of the institute; and of women's organizations, service clubs and other welfare groups. The co-operation of these organizations outside of the institute has materially aided in making the program more fully effective.

Organizations and clubs formed by the blind have been foremost among all agencies in assisting the institute to formulate its policies and help make them effective. The courage and co-operation of individual blind persons have afforded inspiration and encouragement to all voluntary members of the institute council and boards. We believe that the practical philosophy and cheerful outlook of those blind persons who have been given reasonable opportunity have afforded inspiration to the people of Canada. Every additional evidence of thoughtful understanding and practical assistance by governments and the people of Canada have brought a ready and most encouraging response from the blind. If recommendations of the Dominion Council of Health and this institute are now combined and given effect they will constitute the most comprehensive program of services for the blind and the prevention of blindness that have yet been devised for Canada. It is now our earnest hope that the committee will, in its wisdom, accept these recommendations.

EXHIBIT "A"

*Schedule of Earnings Under Scheme of Graduated Pensions Rates for
Single Persons*

Earnings	Pension	Income	Earnings	Pension	Income
\$200	\$240	\$440	\$450	\$115	\$565
210	235	445	460	110	570
220	230	450	470	105	575
230	225	455	480	100	580
240	220	460	490	95	585
250	215	465	500	90	590
260	210	470	510	85	595
270	205	475	520	80	600
280	200	480	530	75	605
290	195	485	540	70	610
300	190	490	550	65	615
310	185	495	560	60	620
320	180	500	570	55	625
330	175	505	580	50	630
340	170	510	590	45	635
350	165	515	600	40	640
360	160	520	610	35	645
370	155	525	620	30	650
380	150	530	630	25	655
390	145	535	640	20	660
400	140	540	650	15	665
410	135	545	660	10	670
420	130	550	670	5	675
430	125	555	680		680
440	120	560			

EXHIBIT "B"

SCHEDULE OF EARNINGS UNDER SCHEME OF GRADUATED PENSIONS

RATES FOR MARRIED PERSONS

Earnings	Pension	Income	Earnings	Pension	Income
\$ 565	\$240	\$ 805	\$ 815	\$115	\$ 930
575	235	810	825	110	935
585	230	815	835	105	940
595	225	825	845	100	945
615	215	830	855	95	950
625	210	835	865	90	955
635	205	840	875	85	960
645	200	845	885	80	965
655	195	850	895	75	970
665	190	855	905	70	975
675	185	860	915	65	980
685	180	865	925	60	985
695	175	870	935	55	990
705	170	875	945	50	995
715	165	880	955	45	1,000
725	160	885	965	40	1,005
735	155	890	975	35	1,010
745	150	895	985	30	1,015
755	145	900	995	25	1,020
765	140	905	1,005	20	1,025
775	135	910	1,015	15	1,030
785	130	915	1,025	10	1,035
795	125	920	1,035	5	1,040
805	120	925	1,045		1,045

The CHAIRMAN: Thank you, Mr. Myers. Are there any questions to be asked Mr. Myers?

Mr. DONNELLY: I should like to ask Mr. Myers if the pensionable age were raised from forty down to twenty-one how many extra men would that bring in and what would it cost.

Colonel BAKER: We have not figured the exact cost, sir, but since we find that in the large group twenty-one to forty we have the highest incidence of employability, and since we have already presently 1,631, I believe, registered with the institute in the age group, of whom 565 are full-time employed, some 822 are part-time employed or married women with household duties, and that only about 244 approximately are rated as unemployed due to multiple disabilities in addition to blindness, I feel that the number probably would not be in excess of 400, somewhere between that, it might run to 500, of that age group. The Dominion Council of Health, I believe, sir, have put in an estimate of that.

The CHAIRMAN: Are there any other questions?

Mrs. CASSELMAN: May I ask if there is any allowance or pension given to those under twenty-one?

Colonel BAKER: No, Mrs. Casselman. The children under school age, of course, are cared for in the home. The children of school age are accepted in most if not all of the provinces as wards of the provincial governments with maintenance and tuition provided for the ten months of the school year, and they carry them then through public and up through high school and they will carry them to the age of twenty-one.

Mr. BLANCHETTE: I have one question to ask, but before asking that question, if I may be permitted to do so, I should like to express my appreciation of the brief presented here this morning, as being one of the most moderate and the most reasonable that has been presented to us during this sitting. I do not know whether I have been more receptive this morning than I have been in previous sittings, but I think this is the first time that we have had a brief presented to us that takes into consideration the taxpayer. Throughout the whole brief that idea seems to be stressed, and I think the committee is very thankful for the submission which has been rendered to us this morning.

We have had Colonel Baker before us in other committees, and this morning he has been true to form, as well as Mr. Myers, in making his brief very interesting and precise.

Amongst our distinguished visitors here this morning we have Dr. Gregoire of Quebec, who is the deputy minister of that province. I should like to bring forth to the committee the fact that Dr. Gregoire has co-operated with this committee in having presented at Quebec Bill No. 51, which, I understand, has now passed, creating a health insurance commission.

The question I should like to ask is this. I see on page 14 of the brief the following: "Since the passage of the Blind Workmen's Compensation Act (Ontario 1931), no blind worker employed in industry outside of the Canadian National Institute for the Blind and who at the same time was subject to the provisions of the Act has incurred an accident involving loss of time chargeable to the consolidated revenue account of the province of Ontario." Is there any other province which has passed similar legislation?

Colonel BAKER: Not yet. I believe there is a bill at the present time under consideration in the province of Quebec.

Mrs. CASSELMAN: May I just follow that up by saying that this brief also shows that there is decidedly a place where the voluntary organization can do work in this country. I do not think any government agency can do for the blind what this institute has been able to do. I think there is a place, of course, for government help, absolutely, but it also seems to me it illustrates once again how necessary a voluntary organization is in the work because of the keen personal interest and individual attention they give to those who come to them.

Now, this question arises in my mind: Suppose government help is increased, the Canadian Institute for the Blind does not intend to lessen its efforts, does it?

The WITNESS: Not at all, increase it.

Colonel BAKER: We have tried to suggest also that following the granting of a pension in 1937 we have been able through funds released and opportunities afforded to more than double the employment. It is our earnest hope, by our present status and by co-operation of the government in this, in line with these recommendations this morning, that we may be able to go on where we may be able to see that every blind person's employability, of whatever degree, is being utilized to the fullest extent. That is our objective.

The CHAIRMAN: Colonel Baker, how do you account for the great increase of gainfully employed blind workers from 1935 to 1943, with the consequent great increase in income; is that through an educational process or individual attention?

Colonel BAKER: Part of that increase is due to the fact that with funds released on relief account with the granting of pensions to the blind we were able to more specifically press our employment services and expand them; secondly, we have been learning a good deal in the meantime not only from our own efforts in this country, but from information we have been able to pick up from other countries, and, finally, there are two factors which you must not ignore. First,

there is a better public understanding of its duties, and readiness to accept the blind worker on the part of the employer, and, secondly, there is the wartime shortage of labour and the opportunities that have come through that.

The CHAIRMAN: It shows very remarkable progress.

Colonel BAKER: Yes, sir.

Mr. GERSHAW: Could the witness tell us more specifically as to what could be done in the prevention of blindness. For instance, some provinces make it necessary for medicines to be placed in the eyes of children when born.

The CHAIRMAN: Dr. MacDonald, will you comment on that question?

Dr. J. A. MACDONALD: Mr. Chairman, ladies and gentlemen, I appreciate very much the honour that is mine in having this opportunity of making a few observations, particularly with respect to the question which was asked just now in relation particularly to the prevention of blindness. Our institute attaches a great deal of importance to that particular subject. People who enjoy the priceless gift of sight may theorize in an abstract way as to the importance of preventing blindness, but I think we may be permitted to say that those of us who have had to travel that long up-hill road of physical darkness are in a better position to know the intimate factors involved. It was with profound satisfaction that I listened to the voice of my great friend Dr. Jean Gregoire of Quebec to-day as he put forth the summary of the recommendations of the Dominion Council of Health relative to the investigations, studies and treatment at public expense of the thousands of men and women throughout this country threatened with blindness and who may not have received proper attention and therefore would be placed in that group of those who, sooner or later, would require assistance as blind people.

Now, how much blindness is preventable? That is a question that is very difficult to answer with any degree of accuracy, but those who have investigated the many factors of blindness state rather confidently—many of them—that from 50 to 60 to 75 per cent is unnecessary. We do know that there are certain conditions which would yield to treatment of a local nature which are responsible for the destruction of eyesight. Ophthalmia neonatorum is almost completely conquered, glaucoma yielded, trachoma can be eliminated. Much can be done in large part to overcome and assist those conditions. Then we have other conditions for which, through prophylactic or recourse to surgical or medical relief, much can be done to relieve them. Then, in the way of preventing industrial accidents, there should be no question whatever that those accidents should not occur and that in many cases of injury, if they had proper care at the proper time, much blindness could be prevented. We know that many a toiler is brought into the darkened life at the time of his prime and vigour and it is quite unnecessary. I do not think we can blindly subscribe, hook, line and sinker, to some of the things we read, although we read them in authentic medical journals, that all kinds of blindness are preventable. I read in an American journal not long ago 75 to 80 per cent, certainly a lot of blindness is preventable, but now I would like just to glance for one minute at the figures that were given to-day in the statement of the institute.

If you wish to analyze the 6,400 odd cases we know that with timely skill and proper attention to these cases including attention to the conditions which invade the structures of the eye and produce eye damage, we may be sure that a very considerable proportion of blindness from local and general diseases could be checked. There were 545 of these cases due to industrial and chemical causes, and I have already said that that is a condition that should not be permitted. That may be overcome.

Now, about our children in school; I do not know who would dare estimate the number of boys and girls in our schools to-day suffering from sequela and infectious diseases leading to incipient eye trouble which if not checked will sooner or later lead to inevitable serious impairment of sight if not total blindness.

Now, many of these children should not actually be studying in the ordinary school classes at the ordinary school desks, reading the ordinary school books. We know that science has brought it out and yet we must admit that it is inevitable that these children be considered as candidates for specialized classes. Classes throughout the country have been developed and designed for their needs, but it is to be regretted that only in a few centres in this country have the well administered facilities been taken note of. It is true the cost may be a little more, but how insignificant in comparison with the cost of blindness, the cruel cost to the individual and the wasteful cost to the state. A broad all-embracing program of prevention of blindness would be very difficult for any private agency. The Canadian National Institute for the Blind has done an enormous amount of work during the past twenty-five years and it has faced up to the seriousness of the problem. With the resources which we have available the co-operation of welfare agencies and service clubs throughout the country we have no doubt been responsible for the saving of the eyesight of thousands of men, women and children. The ultimate satisfactory solution, complete solution of the problem, calls for determined and continuous and united action on the part of the federal and provincial governments as outlined by Dr. Gregoire's presentation to-day. We agree with those who declare that the issue of prevention will in time be discovered to be a fundamental one in regard to the blind, and it may indeed come to pass that all the plans that we are considering now and the plans actually in execution for the benefit of sightless people will be regarded as temporary or provisional because of the fact that the causes of blindness are relatively less obscure than are the causes of many other of the defects and diseases which beset the human race. Blindness should be one of the first of such diseases to be eradicated.

With such promises made the situation may already be that we have if we take vigorous, determined and unceasing action arrived at the place where the end may be hastened in a measure we cannot now realize. There is but one slogan for the authorities to adopt, keep up every effort for the prevention of blindness, every effort that will make for the preservation of life's most precious possession.

The CHAIRMAN: Thank you, doctor.

(Dr. MacDonald then made a few remarks in French.)

The CHAIRMAN: Could you give us a word in Gaelic?

Dr. MACDONALD: Yes, I could give you a word in Gaelic, but I am afraid there would be no one here who could understand it.

The CHAIRMAN: Oh, yes there is.

Mr. GERSHAW: Mr. Chairman, probably this question is not in order, but as has been indicated the very common cause of blindness is gonorrhea ophthalmia, and that is the kind which can be almost certainly and very easily prevented. My question is: Is it compulsory by law for some silver preparation to be instilled into the eyes of children when born to prevent this particular form of blindness?

Dr. GREGOIRE: I know it is not compulsory in Quebec, but we distribute silver nitrate to every physician through our health units. It is not compulsory to put silver nitrate in the eyes of the babies, but I hope it is being done.

Mr. BLANCHETTE: But you are using it?

Dr. GREGOIRE: Yes, we use it.

Colonel BAKER: I may say, Mr. Chairman, that I know of one school for the blind in Canada, for instance, where thirty years ago 35 per cent of the pupils in attendance had lost their eyesight as a result of ophthalmia neonatorum; two years ago less than 10 per cent of the pupils in attendance were there through that cause.

The CHAIRMAN: Dr. Cypihot.

Dr. H. Cypihot, called:

The WITNESS: Mr. Minister, Mr. Chairman, ladies and gentlemen, it may be opportune to submit my credentials to the honourable members of this committee. For twenty-five years I have been closely connected with the Nazareth Institute of Montreal, which is the oldest institute in Canada. For thirteen years I have been president of the C.N.I.B., Quebec division.

I have examined minutely the brief which has been so brilliantly presented to you by Colonel Baker and his colleagues.

May I stress two points specially for the well being of the blind: First, keep them working for the benefit of their morale, thus avoiding monotony and idleness by self-support, and they will become better citizens. In this case may I say there is the co-operation of the state and of the individual. My second point is this: for those who cannot support themselves, give them a reasonable living allowance. This allowance should be granted, in my humble opinion, upon a sliding scale, as it appears in schedules A and B, which you have received.

May I add that I fully concur in the efforts made for the betterment of the welfare of the blind and that I give my full support to the conclusions of the brief.

(Dr. Cypihot makes the same remarks in French.)

Mr. MACINNIS: Mr. Chairman, I wish to draw attention to the remarks made in English by the last speaker in reference to the sliding scale. Before I do that may I associate myself with the others who made reference to the excellence of this brief? I was struck both with its simplicity and with its reasonableness; but I wish to refer particularly to the desirability, in my opinion, of including in any pension scheme for the blind or in anything that may come under the Health Insurance Act for the blind the sliding scale referred to in this brief. I have always considered that man was not just merely a physical being that could be kept at his best by a sufficient amount of the essentials of life to keep body and soul together. There is nothing more depressing and nothing that retards proper human development more than for a person to have to exist on a mere minimum that will just keep body and soul together. It is essential for a human being to live at his best to see before him some opportunity for progress, and it is for that reason that I would urge that this committee in anything we do we do not overlook this matter of the sliding scale.

The CHAIRMAN: Are there any other questions? On your behalf I should like to express your thanks to the representatives of the blind for their very constructive brief and their very excellent presentation. I need not add anything to what Mr. Blanchette and Mr. MacInnis have said with regard to the presentation.

Mr. MYERS: Mr. Chairman, before you adjourn Captain M. C. Robinson, the director for western Canada of the Canadian National Institute for the Blind, would like to make a statement in connection with pensions.

Captain M. C. Robinson, called:

The WITNESS: Mr. Chairman, ladies and gentlemen, Dr. MacDonald and others have said that blindness is a tragedy, but when blindness is associated with poverty then it becomes a great tragedy.

Now, before this meeting adjourns, on behalf of the blind people whom this brief and subsequent legislation will affect, I should like to leave in your minds as clear a picture as possible of the individuals who are to be affected. The question has been raised that the age limit be reduced from 40 to 21. Immediately my mind goes out to a young man who for some seven years supported his mother and then became sick; but he became sick in mind and was admitted to a mental hospital and there passed the next six years. After that time, although far from well, he was well enough to be discharged providing his mother, an aged woman, was able to support him. He was discharged from the hospital and his mother to-day is supporting him. That is the type of case whom we are attempting to assist when we recommend that man thirty-five years of age. Why should he wait for another five years in order to qualify for the pension. That is the type of person who is included in this some 500 of whom Colonel Baker has spoken. Then, again, I visited a man who during the last year served his country well as a merchant marine and who to-day is totally blind, and in addition to that is suffering tremendously from gastric ulcers.

Now, ladies and gentlemen, although the institute has provided him with a radio and a Braille watch and the services of our home teachers, that man is unable to live and take care of himself adequately on the pension as it is based to-day; and it is because of that that we ask for an increased basic rate in our pension. That is what the blind want and that is what they need, and so we ask that the basic rate be increased and that it be tied in to the cost-of-living index. That man is totally blind and his position is far different from the individual with guiding vision. To illustrate, you may put four or five or six layers of gauze in front of your eyes and you will have some conception of what our border-line cases can actually see. Through these layers of gauze you can come into this room through that door, find yourself a seat and go out. It is true you could not compete with sight labour and therefore you do require a pension, but your needs are not so great as the man who is totally blind who cannot because of the total blindness and other physical infirmities provide for himself beyond that which is provided for him in the pension. It is because of those individuals that we feel some differentiation should be made; in other words, there should be a guiding or a special assistance allowance of some kind to take care of these people who are totally blind, over and above those with guiding vision.

Then my mind goes back to a man from the maritimes now out in Alberta who for years tuned pianos in the Crow's Nest Pass. He rode on freight trains and section handcars up and down there before the institute came into existence. Since then he has been established in Calgary. To-day he is receiving pension for the blind and he is earning \$200 a year in addition to that pension; but there is no incentive whatsoever for that man to earn anything more than that \$200 because at best he can only earn another \$200 and it would be of no advantage to him because for every dollar he earns one dollar would be cut off his pension. So we suggest in this brief that only 50 cents be cut off each additional dollar over the amount now provided.

Then again I think of a man who came out here from Scotland when he was about forty-eight years of age. He was over here three years when he lost his sight. That man has now been here for some fifteen years and still has to remain here for another five years before he can qualify for pension. We realize that in so far as the Old Age Pension Act is concerned that a residence requirement is absolutely necessary and probably twenty years is quite justifiable, but in respect to a man who comes into this country with no eye defect, because he cannot come in if he has an eye defect, and he loses his eyesight here, should he have to

remain for twenty years as a blind man before he can qualify for the pension? We do not think so; and therefore we have suggested that that residence requirement be reduced to five years.

And with all these different factors and requirements in addition to the prevention of blindness it has been suggested that a separate Act be passed covering these matters, and so, Mr. Chairman, ladies and gentlemen, on behalf of the blind people, whom I am representing here to-day, may I add my word to the closing remarks read by Mr. Myers to the effect that this committee will give sympathetic consideration to the brief which has been presented.

The CHAIRMAN: Colonel Baker, have you any comment?

Colonel BAKER: No I have not except to thank you and members of this committee for your very patient and kindly reception of our submission and to thank Dr. Gregoire; and I wish to assure you, sir, that if we can co-operate in any further way with you through provision of information that you may desire we will be only too happy to do it, sir. Thank you very much.

The CHAIRMAN: We shall adjourn now until Tuesday the 22nd at 11 a.m.

The Committee adjourned at 12:45 to meet again on Tuesday, June 22, at 11 o'clock a.m.

APPENDIX A

THE CANADIAN NATIONAL INSTITUTE FOR THE BLIND AGE CLASSIFICATION—BLIND PERSONS IN CANADA NOVEMBER 30, 1942

Registered C.N.I.B.	12,344
Male, 7,118; females, 5,226.	
70 years of age and over	3,422
40-69 years of age	6618
21-39 years of age	1,631
20 years of age and under	673
Classified as follows:	
Married women	3,474
Single women	1,752
Nil or light perception	5,558
Guiding sight	6,786
Mental—in institutions	189
Mental—not in institutions	315
Old age pension	710
Workmen's Compensation Board	136
Mothers' allowance	164
Blinded soldiers	119
Blind pension	5,806
Indians registered—not included in the above analysis....	144

November 30, 1942

SOCIAL SECURITY

645

	P.E.I.		N.S.		N.B.		QUE.		ONT.		MAN.		SASK.		ALTA.		B.C.		GRAND TOTAL									
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.										
Registered C.N.I.B.— 70 years and over, 1872 or earlier.	18	25	43	135	136	271	119	117	236	389	466	855	581	531	1,112	131	77	208	133	86	219	119	65	184	174	120	294	*3,422
			16			112			95			381			423			68			85			63			103	1,346
Classified as follows:— Married Women.				9		24			22			85			108		9				1			2			17	277
			14			150			131			562			585		95				121			66			111	1,835
Guiding Sight.			29			121			105			293			527		113				98			118			183	1,587
Mental—not in Institutions.						2			2			12			13						3			2			1	35
Mental—in Institutions.			1			3						4			14		3				2			4				31
Old Age Pension.			2			53			23			42			339		45				50			81			75	710
Workmen's Comp. Board.						4									6		1				1			2			1	15
Mothers' Allowances.															5		1											6
Blinded Soldiers.						1			1						2													4
Blind Pension.			34			140			177			377			331		71							48			81	1,327
Indians registered—not included in the above analysis.			1			1			2						6						26			5			19	66

*Males, 1,799; Females, 1,623.

THE CANADIAN NATIONAL INSTITUTE FOR THE BLIND
AGE CLASSIFICATION — BLIND PERSONS IN CANADA
November 30, 1942

	P.E.I.			N.S.			N.B.			QUE.			ONT.			MAN.			SASK.			ALTA.			B.C.			GRAND TOTAL	
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.					
Registered C.N.I.B.— 40-69 years, 1902-1873.....	35	27		62	287	194	481	234	201	495	1230	955	2,185	1210	736	1,966	225	140	355	166	124	290	196	112	308	319	147	466	*6,618
Classified as follows:— Married Women.....			18				124			201			651			558			98			106			87			119	1,962
Single Women.....			9				70			60			304			198			42			18			25			28	754
Nil or Light Perception.....			17				213			182			983			860			142			124			99			164	2,784
Guiding Sight.....			45				268			313			1,202			1,106			223			166			209			302	3,834
Mental—in Institutions.....			3							2			26			34			15			1			5			14	100
Mental—not in Institutions.....							22			10			23			50			3			5			5			4	122
Old Age Pension.....																													
Workmen's Comp. Board.....							15			2			7			47			4						5			17	97
Mothers' Allowances.....							3						1			98			3			8						18	131
Blinded Soldiers.....										2			10			68			4			1			7			15	109
Blind Pension.....																													
Indians registered—not included in the above analysis.....			49				354			418			1,796			1,043			240			179			160			240	4,479
							1									11			7			16			11			13	59

Males, 3,902; Females, 2,716.

THE CANADIAN NATIONAL INSTITUTE FOR THE BLIND
AGE CLASSIFICATION — BLIND PERSONS IN CANADA
November 30, 1942

	P.E.I.		N.S.		N.B.		QUE.		ONT.		MAN.		SASK.		ALTA.		B.C.		GRAND TOTAL									
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.		T.								
Registered C.N.I.B.— 21-39 years, 1903-1921.....	3	8	11	74	59	133	65	28	93	304	154	458	304	200	504	73	35	108	70	33	103	56	45	101	72	48	120	*1,631
Classified as follows:— Married Women.....						13			9			18		73			7			7				19			17	163
Single Women.....			8			46			19			136		127			28			26				26			31	447
Nil or Light Perception.....			4			67			45			229		177			36			39				30			49	676
Guiding Sight.....			7			66			48			229		327			72			64				71			71	955
Mental—in Institutions.....						1						9		19			4			2				2			4	41
Mental—not in Institutions.....			2			14			12			16		31			7			9				7			3	101
Old Age Pension.....																												
Workmen's Comp. Board.....						1			4			1		8			5							1			4	24
Mothers' Allowances.....												1		23			1			1							1	26
Blinded Soldiers.....						1			1					2						1								5
Blind Pension.....																												
Indians registered—not included in the above analysis.....														5			1			2							5	13

*Males, 1,021; Females, 610.

THE CANADIAN NATIONAL INSTITUTE FOR THE BLIND
AGE CLASSIFICATION — BLIND PERSONS IN CANADA
November 30, 1942

	P.E.I.		N.S.		N.B.		QUE.		ONT.		MAN.		SASK.		ALTA.		B.C.		GRAND TOTAL									
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.		T.								
—																												
Registered C.N.I.B.— 20 years and under, 1922-1942.....	2		2	19	12	31	23	11	34	117	83	200	133	91	224	30	26	56	27	22	49	28	19	47	19	11	30	673
Classified as follows:— Married Women.....															1			1										3
Single Women.....			2			12			11			83			90		25		21				19			11		274
Nil or Light Perception.....			2			15			19			79			82		23		22				11			10		263
Guiding Sight.....						16			15			121			142		33		27				36			20		410
Mental—in Institutions.....									2						9		1		2				2			1		17
Mental—not in Institutions.....			1			4			3			4			24		7		5				7			2		57
Old Age Pensions.....																												
Workmen's Comp. Board.....																												
Mothers' Allowances.....																												
Blinded Soldiers.....															1												1	
Blind Pension.....																												
Indians registered—not included in the above analysis.....																6												6

*Males, 396; Females, 277.

APPENDIX B

THE CANADIAN NATIONAL INSTITUTE FOR THE BLIND CLASSIFICATION OF CAUSES OF BLINDNESS TOTAL

No. CLASSIFIED: 6,445 JUNE, 1943

	Male	Female	Total
Infectious diseases.. . . .	627	466	1,093
Traumatic and chemical injuries..	420	123	543
Toxic poisoning.. . . .	34	2	36
Neoplasms.. . . .	35	32	67
Non-infectious systemic diseases..	162	188	350
Congenital and hereditary.. . . .	882	643	1,525
Etiology not specified.. . . .	1,557	1,274	2,831
	<hr/> 3,717	<hr/> 2,728	<hr/> 6,445

INFECTIOUS DISEASES—

Diphtheria.. . . .	1
Gonorrhea excluding ophthalmia neonatorum.. . .	4
Measles.. . . .	18
Meningitis.. . . .	37
Ophthalmia neonatorum—Gonorrheal.. . . .	13
Ophthalmia neonatorum—not specified.. . . .	119
Scarlet Fever.. . . .	15
Septicemia.. . . .	1
Smallpox.. . . .	7
Syphilis—congenital.. . . .	9
Syphilis—acquired.. . . .	4
Syphilis—origin not specified.. . . .	257
Trachoma.. . . .	53
Tuberculosis.. . . .	27
Typhoid.. . . .	3
Other Infections specified.. . . .	19
Infections not specified.. . . .	506
	<hr/> 1,093

TRAUMATIC AND CHEMICAL INJURIES—

War.. . . .	24
Firearms.. . . .	6
Explosives specified.. . . .	66
Explosives not specified.. . . .	12
Play or Sport.. . . .	22
Street and Traffic Accidents.. . . .	2
Surgical Trauma.. . . .	12
Birth Injuries.. . . .	4
Industrial Injuries specified.. . . .	3
Industrial Injuries not specified.. . . .	—
Non Industrial Injuries specified.. . . .	4
Non Industrial Injuries not specified.. . . .	8
Injuries specified.. . . .	242
Injuries not specified.. . . .	138
	<hr/> 543

TOXIC POISONING—

Tobacco..	2
Alcohol Ethyl..	5
Alcohol Methyl..	22
Other poisons specified..	6
Other poisons not specified..	1
	<hr/>
	36

NEOPLASMS—

Brain..	55
Other..	12
	<hr/>
	67

NON-INFECTIOUS SYSTEMIC DISEASES—

Anemia..	3
Diabetes..	93
Nephritis..	36
Vascular..	197
Non-infectious diseases of central nervous system..	10
Diseases of Pregnancy and Childbirth..	—
Other Systemic diseases specified..	8
Other Systemic diseases not specified..	3
	<hr/>
	350

CONGENITAL AND HEREDITARY—

Congenital (this includes all congenital cataracts, myopes, etc.)..	1,256
Hereditary and Familial (mostly retinitis pigmentosa)..	269
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	1,525

ETIOLOGY NOT SPECIFIED—

Unknown to Science (this includes all glaucoma, pemphigue, etc.)..	730
Undetermined by Physician (942 of these are senile cataracts)..	2,101
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	2,831

APPENDIX C

BRIEF PRESENTED BY LA CONFEDERATION DES TRAVAILLEURS CATHOLIQUES DU CANADA (FEDERATION OF CATHOLIC WORKERS OF CANADA) TO THE COMMITTEE OF THE HOUSE OF COMMONS AT OTTAWA, APPOINTED TO EXAMINE AND REPORT A PLAN OF HEALTH INSURANCE AND OTHER RELEVANT MATTERS. JUNE 15, 1943.

LA CONFEDERATION DES TRAVAILLEURS CATHOLIQUES DU CANADA, INC.

Head Office: 19 Caron Street, Quebec, P.Q.

Montreal Office: 1231 Demontigny Street East, Montreal, P.Q.

Ottawa Office: 168 Dalhousie Street, Ottawa, Ont.

MR. CHAIRMAN,

MESSRS. MEMBERS OF THE COMMITTEE:

The Department of Pensions and National Health drew up, last February, a draft bill respecting the establishment of a contributory national health insurance plan. This draft bill is now before your Committee.

The C.T.C.C. is not planning to analyze in detail the draft bill of the Department of Pensions and National Health. It contains excellent suggestions, but it does not seem to us that it provides the necessary protection, and it promises to be specially burdensome for large families.

Our organization believes it expedient to call attention in its present brief to some general ideas that will set forth its viewpoint.

Social insurance schemes (including health insurance) form part of social security programs that have been made public in recent years. In Canada, the application of any scheme of social insurance involves, in certain respects, constitutional difficulties as well as practical difficulties. But these difficulties can obviously be ironed out.

It seems that any contributory health insurance act must be founded on some one of the following five formulas:—

1. Exclusive jurisdiction of the Dominion government, as in the case of unemployment insurance, which would necessitate a further amendment to the British North America Act;
2. Concurrent jurisdiction of the Dominion government and the provincial governments, while leaving the principal initiative in respect of the act to the Dominion government, as obtains in connection with the Old Age Pension Act. That is the formula that is generally proposed in the draft bill of the Department of Pensions and National Health.
3. Concurrent jurisdiction of the Dominion government and the provincial governments, while leaving the principal initiative connected with the legislation to the provincial governments.
4. Exclusive jurisdiction of the Dominion government, on the one hand, and of the provincial governments, on the other hand, each in its own sphere, by taking into account almost identical standards and by making suitable applications, as in the case of workmen's compensation acts.
5. Exclusive provincial jurisdiction, each province acting as it sees fit, without a uniform plan, as, for instance, in the case of minimum wage acts.

Experience with unemployment insurance has not proven satisfactory to the C.T.C.C. Sabotage of the Unemployment Insurance Commission is being carried on at the present time; the number of employees connected with this form of insurance (within the meaning of the act) is insufficient; and it does not seem that any thought is given to an increase in the benefits for large families, notwithstanding the millions of dollars accumulated in the unemployment insurance fund at Ottawa.

Hence, the C.T.C.C. sets aside the first formula in respect of health insurance, and remains distrustful of the above-mentioned second and third formulas, seeing that Ottawa's intervention in the realm of social insurance does not seem to have yielded satisfactory results.

The C.T.C.C. realizes that the fifth formula would lend itself with difficulty to a reasonable application alike from an economic standpoint and a social standpoint, in connection with the establishment of a scheme of contributory health insurance.

But, in our opinion, it would seem that the fourth formula might be given a trial. And if all the interested parties co-operate sincerely, the C.T.C.C. is convinced that this procedure would be crowned with success.

Such being the case, in order to work out a satisfactory contributory health insurance scheme, the C.T.C.C. suggests that the Dominion government and the various provincial governments each appoint a health insurance commission to study, prepare and perfect a contributory health insurance bill, centred on the family, a measure that can easily be put into effect, alike from an economic standpoint and a social standpoint, and the application of which could be carried out without running counter to the Canadian constitution.

Respectfully submitted,

LA CONFEDERATION DES TRAVAILLEURS
CATHOLIQUES DU CANADA, INC.

(The Federation of Catholic Workers
of Canada, Inc.)

June 15, 1943.

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Canada - Social Security Committee

SESSION 1943

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HOUSE OF COMMONS

SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 24

TUESDAY, JUNE 22, 1943

WITNESSES:

Mr. M. L. Cole, Toronto, Ont., representing the Chiropodists.
Mr. Robert Smith, Hamilton, Ont., representing the Chiropodists.
Mr. D. D. Bruce, Toronto, Ont., representing the Chiropodists.
Mr. N. D. Foote, Toronto, Ont., representing the Chiropodists.
Mr. Kaufman, Montreal, P.Q.
Dr. D. S. Louis, representing the Canadian Medical Association.
Dr. A. E. Archer, President, Canadian Medical Council.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943

JUL 3 1943

MINUTES OF PROCEEDINGS

TUESDAY, June 22nd, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Bruce, Casselman (*Mrs.*) (*Edmonton East*), Cleaver, Coté, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Lerclerc, MacInnis, MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIlraith, Mayhew, Picard, Veniot and Warren—26.

Mr. M. L. Cole, Toronto, representing the Chirôpodists of the Dominion, was called. He introduced the other delegates of that organization who were:—

Mr. Robert Smith, Hamilton, Ont.

Mr. J. C. Shorter, Toronto, Ont.

Mr. D. D. Bruce, Toronto, Ont.

Mr. N. D. Foote, Toronto, Ont.

Mr. Kaufman, Montreal, P.Q.

Mr. Cole presented a brief, and he, with Messrs. Smith, Bruce, Foote and Kaufman were examined and retired.

The Chairman thanked the witnesses for their presentation of evidence.

Dr. D. S. Louis, representing the Canadian Medical Association, was called. He stated that the Association wished to make further representations respecting the proposed Health Insurance Bill, and that Dr. Archer would do so.

Dr. A. E. Archer, President, Canadian Medical Council, was called. He presented a brief, was examined and retired.

Dr. Harvey Agnew, Associate Secretary, Canadian Medical Council, was also present.

The Chairman thanked the witnesses and the Committee adjourned at 12.30 p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 22, 1943.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Ladies and gentlemen, we have with us this morning representatives of the Dominion Council of Chiropodists, and I shall ask Mr. M. L. Cole of Toronto to introduce his colleagues.

Mr. M. L. COLE, called.

The WITNESS: Mr. Chairman, Mrs. Casselman, and gentlemen, I have the honour to present to you my colleagues: Robert Smith, J. C. Shorter, D. D. Bruce, N. D. Foote, and I. W. Kaufman.

Now, if I were in the western provinces of Canada or in the United States of America I should address these gentlemen as "doctor," but as it is, being in the province of Ontario, things are just a little bit different. May I be permitted to give the list of the associations that we represent: The Maritime Federation of Chiropodists, the Quebec Association of Chiropodists, the Ontario Association of Chiropodists, the Ontario Academy of Chiropodists, the Manitoba Association of Chiropodists, the Saskatchewan Association of Chiropodists, the British Columbia Association of Chiropodists and the Canadian Council for Chiropodists.

The Chiropodists of the Dominion of Canada wish to express their appreciation to the Social Security Committee for the opportunity of presenting this brief. It augurs well for a comprehensive health insurance plan for the people of Canada that all divisions of the healing arts are being given a hearing and all branches of medicine an opportunity to serve. We are entirely in agreement with the ideas incorporated in national social security, but feel that chiropody as a branch of medicine should be specifically mentioned. In order that the members of the committee may be better informed in the science of chiropody and the field it serves, we respectfully submit the following information.

The following definition expresses the intention of the varying Acts governing chiropody in the United States and Canada:—

Chiropody may be defined as the medical, mechanical, surgical and electrical treatment of the ailments of the human foot, massage in connection therewith, but shall not confer the right to amputate the foot, toe or toes, or the use of anaesthetics other than local, or the use of drugs other than local antiseptics.

The status of chiropody is described by the American Medical Association and contained in a report of an annual meeting in the Journal of the American Medical Association of April 8, 1939, in part as follows:— —

. . . and is of the opinion that the practice of chiropody is not a cult practice . . . Chiropody is rather a practice auxiliary—a hand-aid—to medical practice in a limited field considered not important enough for the doctor of medicine to attend, and therefore too often neglected.

General opinion seems to be that chiropody fairly well satisfies a gap in medical care that the profession has failed to fill. There are several reputable medical colleges whose faculties teach this branch of the healing art to students who later become chiropodists and the Council can see no reasons to declare such teaching by members of this organization to be

unethical, provided that schools in which they teach are connected with approved schools of medicine and recognized standards of pre-medical education are required.

Next month the following resolution of the American Medical Association was recorded in the Journal, May, 1939:—

Chiropody is not a cult practice, but rather is a practice ancillary to that of medicine with a relationship similar to that of dentistry, pharmacy and nursing.

Secular Education

All class "A" colleges of chiropody require as entrance qualification a junior matriculation standing.

Professional Education

Following is the curriculum of the Chicago College of Chiropody and Pedic Surgery, 1942, and is the standard of "A" class colleges of chiropody as herein listed:—

	Hours
Anatomy, including histology, embriology and anatomy dissection	528
Basic sciences, physiology	252
Chemistry	252
Bacteriology, including biology, general bacteriology (lab.), hygiene and sanitation	216
Pathology	144
Chiropody, terminology, history and general didactic chiropody	216
Clinical chiropody, including surgery, strapping, bandaging, shielding, padding and footgear	1,710
Surgery, didactic surgery general orthopedic surgery, pedic surgery and hospital observation of all types of general surgical cases	270
Medicine, history taking, diagnosis, general medicine, didactic medicine, neurology, psychology, psychiatry, dermatology, syphilology, roentgenology, first aid and emergencies	306
Pharmacology and therapeutics, prescription writing, materia medica, pharmacology, physical and physiotherapy	252
Mechanical orthopedics, didactic and clinical, foot-gear, casts, corrective appliances didactic and clinical, massage and manipulation didactic and clinical, mechanical orthopedics	288
Cultural, professional economics, ethics and jurisprudence, history of medicine and chiropody and special lectures	104
making a grand total of	4,538

represented in four scholastic years of nine months each.

A standing of 75 per cent is required and adhered to for pass grade. Upon graduation, the student is granted the degree of Doctor of Surgical Chiropody (D.S.C.) or Doctor of Podiatry (D.P.)

Faculty

The departmental heads in the basic sciences are doctors of medicine. In chemistry and bacteriology laboratory they are usually Bachelors of Science. All other departments are headed by chiropody graduates.

Chiropody Colleges "A" Class—U.S.A.

Chicago College of Chiropody & Pedic Surgery, Chicago, Ill.

Illinois College of Chiropody, Chicago, Ill.

Temple University, Philadelphia, Pa.

Ohio College of Chiropody, Cleveland, Ohio.

First Institute of Podiatry (Long Island University) New York City.

California College of Chiropody, San Francisco, Cal.

As will be noted by reading the curriculum of our professional course, the chiropodists study the anatomy and physiology of the entire body. We also study considerable general materia medica. However our practice is limited to the treatment of the feet, similarly as dentistry is limited to the teeth.

We are, however, due to our training, frequently able to recognize by the condition of the feet some disease affecting the body in general. For example, often we note a great deal of odema particularly in the region of the malloli. Here, after a history of the case is taken, we realize the condition is not of a local nature and might suspect that there is some heart or kidney condition. This patient is then referred to a physician for treatment.

We occasionally see patients with, as they think, an ordinary callous on the plantar surface of the foot, under which may be a perforating ulcer due to syphilis, or we see a corn under which is found a sinus that is very difficult to heal, often due to diabetes mellitus. In these cases cited, again the aid of a physician is recommended where proper treatment for these conditions may be instituted immediately, or certainly much sooner than would be the case if the condition had not been suspected by the Chiropodist.

We might here add that in this particular disease, diabetes mellitus, considered by some to be in the realm of the medical doctor only, the chiropodist, where given the opportunity, is rendering invaluable service. There are now forty-three chiropody clinics established in hospitals throughout the United States, where the feet of diabetic patients receive regular care and attention from chiropodists. Men such as Drs. Joslin, McKittrick, Wilder and others, have given this service much credit in the markedly decreased incidence of diabetic gangrene in their work.

Wolff's Law of Structure and Function states: "Every change in the form and position of the bones or their function is followed by certain definite changes in their internal architecture and equally secondary alteration of the external conformation in accordance with mathematical laws."

According to this, the body alignment may be incorrect if the foot is not functioning properly. It would seem apparent, therefore, that impaired foot structure and consequent improper weight distribution are detrimental to general health. The chiropodist by his corrective work alone contributes in no small measure to the health of the community. Possibly one of the most outstanding contributions the chiropodist has made to the general health is in this field of mechanical orthopedics. The sum total of records compiled by individual practitioners reveal the fact that varying degrees of metatarsal arch trouble are present in about 80 per cent of women requiring foot treatments. The chiropodist is very thoroughly trained in the treatment of these conditions and their relationship to the health of the individual. We notice there is still in use professionally several types of metal foot appliances. Generally speaking, this practice has been discontinued by most chiropodists. In those cases where such appliances are required it has been the policy for many years in foot correction to maintain the foot as far as possible in line with the normal flexible function intended by nature. To accomplish this, accurate foot impressions are taken on plaster, wax or parafine, depending on the correction involved and the fine degree of accuracy that we require. From these impres-

sions appliances are fabricated from leather, rubber, rubber compounds, and plastic materials, and used in corrective treatment of pes planus pes cavus, calcaneal spur, singly or in conjunction with mortons toe, and metatarsal depression and dorsal flexion.

Also many cases of anterior poliomyelitis which have received the complete treatment as rendered by the physician are referred to the chiropodist for further localized treatment tending towards improvement in locomotion, weight distribution and relief from painful weight bearing areas. Similarly cases of congenital talpes equinus, Varus and valgus, are referred for like treatment.

It is common knowledge that a person suffering from foot discomfort goes to the chiropodist where, if his conditions is found to be within the scope of chiropody, his suffering is alleviated. In the majority who present themselves for examination we find the disability is of a local nature. Where the source of their discomfort is found to be not localized to the feet, they are referred to the physician, or a medical specialist.

As the provisions of the proposed Act now read, persons suffering from this type of disability, have first to go to the physician for examination then be referred to the chiropodist as the physician does not usually handle this type of disability. It would seem, therefore, that the many thousands of people who are now depending on the chiropodist to treat these foot conditions are required to go to a physician first, if they are to participate, to advantage, in the benefits of the Health Insurance Act, to which they will be contributing. This will place an extra burden on a profession that is already overworked. This overworked position was pointed out in a brief presented by the Canadian Federation of Agriculturists and recorded in the minutes of the committee, book 19, page 540.

The exclusion of chiropodists makes it possible that the people of Canada will be required to contribute to the fund but will be restricted to a medical practitioner if they need foot care. The treatment of which is just as essential to their health and well-being as any other form of disability. If they wish to go to their chiropodists they will have to do so at their own expense and without help from the fund they have helped to create.

During the last twenty-five years the science of chiropody has advanced very rapidly. At first it was thought that a course of two to three years would be sufficient to embrace all that was required. But it has become evident that to keep pace with the advance of general medical and scientific knowledge and the clinical training peculiar to our own special field, this course would have to be lengthened. So that now all recognized colleges give a course of four years comprising not less than 4,500 hours, with the prospect of further increase in the near future.

We submit that the chiropodist who has received the benefit of such a training, specializing in one small section of the medical field is better equipped than anyone else to perform these services.

It is conservatively estimated that the chiropodists of Canada during 1942 treated approximately three-quarters of a million patients. This would tend to substantiate the aforementioned statement in the American Medical Journal "Chiropody fairly well satisfies a gap in Medical care that the medical profession has failed to fill."

We would like to draw the attention of this committee to the fact that the government recognizes the need for chiropodists in the armed forces. There is now supposed to be a chiropodist in every military hospital of 200 beds or more. May we not suggest if our services are necessary for the armed forces, provision should be made for our inclusion in health proposals such as this committee has under consideration?

We feel that a very great deal more data may have been presented at this time on behalf of our profession. However, in the interest of brevity we have limited ourselves, but feel that the facts submitted are sufficient evidence that no plan of national security would be complete if we are not included.

Therefore, we would respectfully recommend that the wording of the benefits covered in this plan in clause 27, sub-section 2, should mention chiropody specifically by name.

I have here three documents that were sent to me by the Saskatchewan Association of Chiropodists which we would like included in the record.

The CHAIRMAN: They will be filed with the committee. Now are there any questions which the members of the committee wish to ask Mr. Cole?

By Mr. McCann:

Q. May I ask firstly, how many members of your different organizations there are in Canada, and secondly, whether there is any training school in Canada; and whether those who are practising this art are all graduates of American schools?—A. There are 150 members of our association in Canada. In answer to your second question I may say that there is no school in Canada. We did take that matter up with the Dean of Medicine in Toronto several years ago and his reply was that he did not think, after a survey, that there would be sufficient students at that time to warrant the inclusion of that subject, and he left it open to some future date when, possibly, something might be done. There are the American schools and the English schools.

Q. I notice on the first page of your brief the following statement: "Next month the following resolution of the American Medical Association was recorded in the *Journal*, May 1939: 'Chiropody is not a cult practice, but rather is a practice ancillary to that of medicine with a relationship similar to that of dentistry, pharmacy and nursing.'"

Now, I am sure that you have noted in the Act that ancillary services may be used. Are you satisfied with that definition which is outlined by the American Medical Association that the place which chiropody would be given would be as an ancillary service? Further, in view of the fact that there are only 150 chiropodists practising in the whole of Canada, I am sure that the gentleman who presented the brief knows that if the total population of Canada were free to make a choice of chiropodists rather than being referred to chiropodists by members of a profession who number 11,000 or 12,000 that they would be overrun with work, and as they stated in their brief, there would be many of those cases which they would have to refer back to the medical profession. I may say, Mr. Chairman, that I think the brief is a very fine brief and that it is a very modest one respecting any requests that are made; and it is a brief which I am sure the committee will give attentive consideration to.—A. Mr. Chairman, may I ask Mr. Robert Smith to answer the question asked by Dr. McCann.

Mr. SMITH: The chiropodist profession in Canada has largely been restricted by the various hindrances which various provinces have placed upon it. In the United States where the colleges really exist and have existed for a long time—of course there is a greater population—we concede that—but where the colleges exist and large numbers of chiropodists have been turned out we find that the population has automatically been drawn to these qualified practitioners.

Now, we find that 80 per cent of all the women coming to us suffer from one single condition alone, metatarsal trouble, and of the total number of people in Canada a conservative estimate would be that at 50 years of age 90 per cent of the individuals have foot trouble of some kind or another. Now, that obviously rules out any possibility of 150 chiropodists treating all of these people, but these 150 can make a great contribution, and if chiropody is recognized there

will be an obvious increase in the number of men and women who will handle these cases. Unfortunately, at the moment, we are not able to bring chiropody to the attention of the public largely because of these various hindrances.

It is our proposal to increase the status of chiropody in Canada. It is the desire of all the associations to endeavour, to the best of their ability, to improve educational standards for students and for graduation, and to continue to improve methods. We have associations and academies to improve the efficiency of all techniques, to speed them up and at the same time to improve our work.

Our purpose would be really this: we want to try to handle as many people as possible at the moment. We know that in twenty years from now chiropody is going to be vastly changed; there will be more chiropodists and there will be more people to treat. At the moment our 150 are doing the limit, and we handle about a quarter of a million—

Mr. McCANN: 750,000 was the figure given.

Mr. SMITH: Pardon me, I should have said three-quarters of a million.

Mr. McCANN: That would be one chiropodist to about 8,000 patients.

Mr. SMITH: Yes. If you came to my office personally I am sure you would be surprised how we do get through our work, in an effort to accommodate as many people as we can who are looking for help. We feel that chiropody should be advanced, and if chiropody is incorporated in the National Health Insurance Act it will improve the status of the profession as an entity, and will also help people to appreciate the value of chiropody.

Unfortunately, there are under present conditions—I am speaking of the Province of Ontario where I practise—many unqualified people. That situation is one of the things that our profession is trying to clear up in order to protect people from unqualified people. We are not asking anything for them, but only for recognition for qualified men who have gone through training such as is described. I trust that will answer your question.

Mr. McCANN: What is the standard in Ontario? What restrictions are there? What is the law that guides in Ontario? Do you have to pass an examination before a board of regents, and, if so, is that board of regents composed of members of your own profession; or how is it done?

The WITNESS: Twenty-five years ago there was no rule or regulation for chiropody. At that time it was decided to form what is known as the board of regents whose purpose would be to give licences and to look into the qualifications of all people who would hold the degree of doctor of medicine. We were asked to come under that, as well as these others, for the reason that it gave the most important protection that any local Act could give—that is that persons practising chiropody had to be graduates of a recognized school and had to pass such examinations as the board set. Since that time, whenever it is possible for the board to obtain sufficient evidence against anyone who is unqualified, those persons have been prosecuted, and in every instance we have received a conviction.

Mr. LALONDE: Has your profession any legal status in the province of Quebec?

Mr. KAUFMAN: Mr. Chairman, ladies and gentlemen, actually there is no law governing the practice of chiropody in the province of Quebec, but our association is given to understand that there is a tacit agreement between the College of Physicians and Surgeons in the province of Quebec and ourselves that as long as we conduct ourselves as chiropodists—in other words, practice chiropody and do not even attempt to infringe upon medical practice—we will be tolerated, and to-day this is just what has occurred; they permit us to practice.

Mr. LALONDE: How many practitioners are there in the province of Quebec?

Mr. KAUFMAN: Approximately thirty-five or forty.

Mr. MACINNIS: Have you got into any jurisdictional disputes?

Mr. KAUFMAN: No, sir, not since the association was established about seven years ago.

The CHAIRMAN: There is one point on which I am not wholly clear. On page 1 of your brief, paragraph 4, you quote a report of an annual meeting of the American Medical Association appearing in the journal of that association of April 8, 1939, in part as follows: "Chiropody is rather a practice auxiliary—a hand-maiden—to medical practice in a limited field considered not important enough for the doctor of medicine to attend, and therefore too often neglected." Does that imply that the patient goes first to the medical practitioner who, in turn, passes the case on to the chiropodist?

The WITNESS: No, sir, in the United States that is not the usual case. I think I am safe in saying that in every state of the American union they have a law permitting chiropodists to practice in a similar manner as dentists and doctors.

The CHAIRMAN: As an auxiliary service; that would seem to be the implication, would it not?

The WITNESS: An auxiliary service if that matter is within the scope of their practice.

The CHAIRMAN: From your own experience could you estimate for the committee the percentage of patients who go direct to the chiropodists as compared with those who go first to the medical practitioners?

The WITNESS: The great majority. Every day or several times a week I have people referred to me by medical practitioners; but the majority come to us first. If we find that the work is not local it is referred to a medical practitioner, but people come to us first if they have a foot discomfort.

The CHAIRMAN: And your very mild objection to the bill is the provision which requires the patient to go to a medical practitioner first?

The WITNESS: Yes. We consider it is a tremendous amount of work for the medical practitioner.

The CHAIRMAN: Apart from that, you support the bill?

The WITNESS: In toto.

Mr. HOWDEN: Is it the practice of the chiropodists to treat congenital foot deformities?

The WITNESS: May I ask Mr. Bruce to answer that question.

Mr. BRUCE: Where we come across a case of a person with a congenital foot disability or a deformity, if we find, for example, a person who has one foot shorter than the other, where there is a deformity from birth, which is congenital, because often it is at the time of birth that it is actually received, we will sometimes attempt by our appliances or massage or manipulation to correct that condition as far as possible.

Mr. HOWDEN: Do you mean in the case of infants?

Mr. BRUCE: We do receive some infants. Personally, I have not seen any infants brought to us. Generally, they go to the orthopedic surgeon for that work.

Mr. HOWDEN: That is what I was wondering about.

Mr. BRUCE: When you speak about congenital foot disabilities there are so many different kinds that you have to be more specific. We do treat some, yes. In that way we are helpful in our massage, manipulation and appliances.

Mr. HOWDEN: So many foot conditions are the result of faulty shoeing, shall I say—bad shoes and high heels—and that does not occur at birth.

Mr. BRUCE: That is acquired, of course. Naturally, we do treat acquired foot disabilities all the time, that is what our main practice is. We might treat some congenital foot disabilities.

Mr. FULFORD: Do you treat advanced cases of bunion?

Mr. BRUCE: Now, that is a question I might answer. So far as a bunion is concerned in the advanced cases, of course, we appreciate that the condition is calloused, and we do not here in Canada go into a great deal of orthopedic surgery. I graduated a year ago in the United States, and in Chicago we do actually treat this condition; we cut right in and remove the section of bone of the growth and from that splint the toe out. However, in Canada, and in my own practice, I may state that where a patient comes to me with a real pain in that area, we do in the great majority of cases alleviate the pain, but we do not remove the bunion, and we refer the patient again to an orthopedic surgeon to let him look after that.

Mr. COTE: Does your treatment include the prescription for special types of shoes? Have you any arrangement with regard to these shoes?

Mr. FOOTE: In that regard, speaking personally, as one conducting more or less an orthopedic practice, I am very particular about footwear. It is seldom that I treat a patient with any mechanical appliance unless a new shoe is obtained. I am not interested in doing anything unless I am reasonably sure that it is going to be definitely satisfactory. In these cases special shoes are prescribed. In cases of ordinary local foot ailments, that is a matter for the individual patients to decide whether they wish to be comfortable and avoid future mechanical foot troubles or go on suffering.

Mr. McCANN: I should like some information as to the schedule of fees which chiropodists follow.

The WITNESS: That depends, of course, on the general practitioners themselves as to what they consider they are worth, to a certain point; but they have a minimum charge of \$2 per person for every person who comes into the office and after that it depends upon what is done as regards mechanical work. It will vary. I can only speak personally but generally the charge would be \$10 or \$15 or \$25 for mechanical work, according to the length of the case. In the case of treatment for an ingrown toenail where there is a mild degree of irritation, or perhaps, infection, or a small corn or something like that, it is dressed in germicide and antiseptic and you probably only see the patient once or twice or three times, and in my own case the bill would be \$5.

The CHAIRMAN: I suppose, as in the case of some other professions, you consider what the traffic will bear?

The WITNESS: We try to, sir. Those persons who cannot afford to pay we treat for nothing.

The CHAIRMAN: Am I to gather from your brief that you work in close co-operation with the medical practitioners?

The WITNESS: Yes. We have always been the most helpful. If I might use the expression jokingly. I have always considered that we occupy the position of the poor relation with respect to the medical profession, but as regards close co-operation, we give it. The physicians refer people to us and we refer people to them. I may say that there are several times a month when I am called into various hospitals for people who have nail conditions or callous conditions, and I treat their condition.

The CHAIRMAN: May I express the thanks of the committee to you and your associates for coming here to-day and for your presentation.

Now, the Canadian Medical Association wish to present a supplementary brief. Dr. Selater Lewis will introduce the subject.

Mr. FAUTEUX: Mr. Chairman, I may be a bit late in what I wish to say because the witnesses are not present, but unfortunately I was late in coming. I think it is my duty to protest about something that appears in the brief presented by the chiropodists. After all, I am the only dentist who is a member of this committee and I should protest against these words: "Chiropody is not a cult practice, but rather is a practice ancillary to that of medicine with a relationship similar to that of dentistry, pharmacy and nursing." I have been practising for many years—

The CHAIRMAN: They quoted that from a report of the journal of the American Medical Association.

Mr. FAUTEUX: It may have been quoted from anywhere, but I want to protest. After all, you are not a dentist simply because you go to a university for four or five years, and although I have a great respect for the medical profession, I do not want my profession to be compared with some of these other people.

The CHAIRMAN: Dr. Lewis, will you proceed please.

Dr. SCLATER LEWIS (President-elect of the Canadian Medical Association): Mr. Chairman, Mrs. Casselman and gentlemen, may I thank you for the opportunity of coming here this morning. In the brief presented by the Canadian Medical Association in April we dealt mainly with the principles related to health insurance. We have, since that time, had an opportunity of studying the departmental proposals for health insurance, and we would like to-day to present further comments respecting the health insurance measure. If I may, I would ask Dr. A. E. Archer, chairman of our committee on health insurance, to act as our spokesman in presenting our comments and to answer any questions.

Dr. A. E. ARCHER, President, Canadian Medical Association, called.

The WITNESS: Mr. Chairman, Mrs. Casselman and members of the committee on social security. It is not our intention this morning to go into any detail as regards suggestions we may have with regard to minor alterations or suggestions in connection with this bill. There are, however, four or five particular points that we should like to have the opportunity of presenting to you.

1. It is observed in the first schedule to this Act that provision has been made for federal grants to be made to the provinces for specific purposes. In our opinion, sympathetic consideration should be given within the framework of this schedule to certain additional grants.

Now in that paragraph of the brief which you have in your hands I draw attention to federal grants which are proposed in the first schedule to the Act. I do not know whether you are all entirely familiar with the form of this Act, but under schedule A there are a list of special grants and we suggest that there are several things which are not there included which might be properly included.

(a) *Bursaries*

The scope and breadth of medical education has become so complex that a long period of study is required to fully educate and train the present-day doctor. Canada normally graduates approximately 550 doctors a year. The exigencies of war have made it necessary to accelerate this production by graduating three classes in the time formerly required for two classes. This has been done at the expense of the former summer vacation period, the length of time for instruction remaining constant. It was quickly recognized by the federal authorities that the almost complete elimination of the vacation period, normally used by students

to earn money, placed a financial handicap upon a great many students. The difficulty was solved by enlisting these students as private soldiers for a period of twenty-four months prior to their availability as commissioned medical officers. So far as the war period is concerned, this plan has proved highly successful.

But what of the post-war period? Unless the time given over to medical education is to be unduly lengthened, vacation periods will tend to become shorter. This may not be a handicap to the sons and daughters of the well-to-do, but it will prove to be a stumbling block to some promising students unless a solution be found.

What is that solution? In our opinion, it is the granting of bursaries or loans. Money so expended will produce dividends to the state the value of which cannot be questioned. These loans could be repaid by services rendered in needy areas. Those graduates who go to the sparsely settled areas in the hinterland of our country, perhaps making real sacrifice so to do, could gradually discharge their loans by such service. The mechanics of the problem should not be difficult to work out.

I should like to draw attention to the fact that in certain countries that has already been done; I think Australia is one of those countries.

It is quite conceivable that bursaries would draw into the medical profession some of its most brilliant minds who otherwise might have been lost to the country in this important field.

(b) Cancer Control

On Friday, May 7, the Cancer Committee of the Canadian Medical Association, in its brief to this committee said the following:—

At the present time, there are at least 50,000 cases of cancer in Canada and about 13,000 deaths from the disease every year. Out of every ten adults, one will probably die of cancer.

Cancer to-day stands second from the top of the list of death-dealing diseases, being exceeded only by deaths from diseases of the heart and arteries. The fight against cancer must be ceaseless and unrelenting until it is mastered. Several of the provinces have instituted certain measures to combat cancer, but the expenditure of much more money on this fight would be required if reasonable success in cutting down the death rate is to be achieved. We would urge, therefore, that federal grants in aid to the provinces should include aid in the fight to conquer cancer.

(c) Post Graduate Education

The schedule provides, *inter alia*, for a grant for professional training. The provisions of this grant should be broad enough to provide for post graduate training of physicians in any branch of the profession where it is recognized by those in authority that such training would assist in raising the standard of medical services to the people as a whole.

(d) Medical Research

Representatives have already been made to this committee by the National Research Council to the effect that grants be made for medical research. The Canadian Medical Association desires to support, whole-heartedly, this proposal.

It is our view that research is a federal matter; that when new information is obtained in any particular subject it is of national value and, therefore, it is a proper proposal for us to make that federal grants be made available for this

important purpose. During the war federal grants have been freely and adequately made, but that has not always been the case in peace time, and we would like to support the proposal of the medical committee of the National Research Council that this be done.

(e) *Industrial Medicine*

We have been impressed by the advances that have been made in the field of industrial medicine. This program should be expanded greatly. Further study of the preventive possibilities of such a program is indicated. Irrespective of whether or not the final basis of cost rests upon industry, it would seem desirable that, in the initial period at least, a federal grant be made available to stimulate the development of this program.

Dr. Cunningham made reference to this program when he was before you some weeks ago.

Now, I would like to draw your attention for a moment to the clause in the federal draft bill, section 4, which reads as follows:—

The statutory provisions as respects health insurance shall be in such terms as to provide health insurance benefits,

(a) of the standards,

(b) under the conditions, and

(c) for the classes of persons,

as set forth in "A Draft for a Health Insurance Act" in the Second Schedule to this Act, or substantially in the terms aforesaid, or in such terms as, having regard for all of the circumstances, for the special conditions affecting the province as a whole, or any special areas in the province, may be accepted by the Governor in Council as a satisfactory practical measure of health insurance for the province.

The foregoing section clearly indicates that very wide latitude is provided, among other things, for the "classes of persons" who are included in the bill which might "be accepted by the Governor in Council as a satisfactory practical measure for the province". In our opinion, such latitude is sound and in harmony with provincial autonomy so long as it does not constitute a weakness in the scheme. It is our view, and, so far as we know, the view of all persons who have given this subject any thought, and all groups, so far as I know, who have appeared before this committee, that health insurance of this character must guarantee the highest standard of service which is possible, and that this high standard of service must be available so far as possible throughout the whole country; moreover, the service must be available to *all* persons below whatever income limit (if any) may be set in the Act, but certainly including those who are unable to contribute for themselves. The clause as drafted would appear to be so broad that it would be within the power of the federal authority to approve a provincial measure which would not include this group which cannot contribute. The language employed in the draft bill and in the model bill for the provinces should be such as would guarantee that these safeguards are present within the Bill.

It was not the intention of the drafting committee that it should be so broad in that particular respect.

3. CLINICAL TEACHING

It is of the utmost importance that the high standard of present day medical instruction be maintained. Were such permitted to deteriorate or be curtailed, the health of the nation would be seriously affected in the years to come. Indeed, the flow of properly educated doctors would be seriously impaired. Opportunities

for clinical observation by students of medicine and undergraduate nurses must not be jeopardized in the health insurance plan. There is abundant evidence over the years that patients in our teaching hospitals associated with medical schools seldom object to the presence of clinical teachers or undergraduates. It should be clearly understood that these patients receive the highest medical and surgical care and are not subject to experimentation. The opinion has been expressed before this committee that patients should not be subjected to or exempted from clinical observation in teaching hospitals on the basis of their ability to purchase private or semi-private accommodation. In our opinion there would appear to be no objection to providing that all patients insured under this plan, whether in general or private wards, should be available for teaching purposes when desirable. It is, therefore, recommended that section 31 (1) (i), page 21, be revised by striking out the words, "except as described in paragraph (h) of this subsection".

That would have the effect of making it possible in any teaching hospital or otherwise that insured people would be available for clinical observation, and that would be governed, of course, by regulations within the hospital, and the rights of the individual could be properly secured everywhere.

Clinical teaching which requires the co-operation of the patient in no sense need offer any indignity to the individual. Actually, the greater the number and variety of diseases which the students of medicine see, the better trained and qualified do they become to recognize and treat diseases when they become practitioners.

There is another clause to which I would like to draw your attention which particularly follows this section, and it is a general clause in the hospital benefits which authorizes the commission to make whatever arrangements may seem to be necessary with teaching hospitals. We have not included it within the written section of this brief but it should have been included. Our desire is that that clause should be so strengthened that the commission would have the power to do whatever might be necessary to solve the problem in any particular teaching hospital. Mr. Chairman, I think that this committee will realize the fundamental importance of clinical teaching. It is the basis of our knowledge and it must be maintained. The rights of the individual must be maintained and we are willing and anxious that there should be no discriminatory clause in this bill; but the rights and necessity of clinical observation, adequate clinical observation and provision for teaching must be maintained. If that clause to which I refer is not broad enough it should be made broad enough to give the commission all the power which it may find that it needs in any individual province.

4. THE APPOINTMENT OF COMMISSIONERS

Section 35, subsection 4, reads as follows:—

The commissioners, except the Chairman, shall as to such number thereof as may from time to time be determined by the Lieutenant Governor in Council, be appointed by the Lieutenant Governor in Council after consultation with organizations representative of medical practitioners, dental practitioners, pharmacists, hospitals, nurses, insured persons, industrial workers, employers, agriculturists, and of such other groups or classes as may from time to time be determined by order of the Lieutenant Governor in Council, provided that at least one Commissioner shall be appointed in respect of each of the professions, hospitals, and each of the remaining classes or groups aforesaid.

It will be observed that this section provides that the commissioner shall be named "after consultation with organizations representative of medical practitioners," etc. While it is appreciated that such consultation would ensure

some measure of guidance in the selection of commissioners, it is quite conceivable that a provincial government, after exercising the formality of consultation, might proceed to appoint commissioners entirely apart from those who were nominated. Believing the inference of this clause to be that advice shall be sought and acted upon, it would appear to be proper to suggest that the words "after consultation with" be struck out and that there be substituted therefor the words "from panels nominated by".

It is axiomatic to say that the success or failure of health insurance in a province will rest to a large degree with the administration. The administration must have the confidence and respect of the people. To the degree that is possible, the commission should have the largest measure of independence which can be attained for it.

I would like to say that from the beginning those of us who have thought much of this matter have considered that it was very important that as far as possible the operation of the commission should be freed from the interference which might at times develop as the result of the vicissitudes of political change.

5. THE FINANCIAL STRUCTURE

If the health insurance should become applicable to the great majority of our people, it will be appreciated that such a change will profoundly affect the medical profession and all others concerned with the provision of services under the Act. Furthermore, it may be argued without fear of contradiction that the medical profession as individuals have perhaps a greater stake in the proposal than anyone else. To the public, health insurance offers a plan by which funds are pooled to pay for medical care. To the medical profession it offers a complete change in medical economics. The profession, therefore, is very much concerned, as it has a right to be, in how the measure will affect it. It is not our province to plan the financial structure, other than to say that the financial structure must be sound so that the measure will not fail because of lack of funds. It would be a great tragedy if, before a fiscal period had passed, it were discovered that there were no more funds available for that period and that the services rendered could not be paid for. It would also be most serious and, we are sure, not contemplated in the plan proposed, if, in times of epidemic or unusual sickness, it were found that the fund would not carry the measure. It would appear to be necessary that there should be provision either for the setting up of a reserve to meet such contingencies or that the fund should be backed by a governmental guarantee of adequacy. We cannot stress too strongly the necessity for continuing the most careful inquiries into the financial problems involved. We feel, also, that the fund should not be part of the consolidated revenue of the province but should be under the complete control of the Commission.

Furthermore, should the commission find that it be in the happy position of having reserves, from time to time, these should be built up against the days of unusual sickness costs such as we know would be the case if the country were swept by an epidemic such as the great influenza epidemic of some years ago.

The last point to which I wish to draw your attention has to do with the problem about which we are hearing a good deal from the men in uniform.

6. DOCTORS ON ACTIVE SERVICE

At the present time, 3,100 of our Canadian doctors, or approximately 30 per cent of our total number, are on active military service. How many more will be required by His Majesty's services we are unable to say, but certainly whatever the number is, they will be provided. The great responsibility rests upon

those of us who remain at home and upon the country generally, to safeguard the interests of those doctors who considered only the interests of all of us when they enlisted. These doctors have had comparatively little opportunity of expressing their views with respect to this measure which will affect them so profoundly when they return home. We should see to it that no action be taken under health insurance measures which would make it difficult for the doctors in the armed services to resume their former practices, or, if recent graduates, to establish practices. The draft measure proposes that all insured persons shall be registered with the physician of their choice. It is foreseen that the setting up of these lists or "panels" during the absence of so many of our doctors, might be distinctly unfair to those who are absent. Either the actual putting into operation of the whole provincial measure should be deferred until the return of the absent medical men, or those clauses in the provincial Act relating to registration and the placing of names on doctors' lists should remain non-operative, or operative only to the degree which concerns the broad aspects of public health and preventive medicine rather than individual service.

We are aware that the perfecting and implementing in the provinces of a satisfactory plan of health insurance will take considerable time. If, however, such a satisfactory plan can be worked out at this time, should its operation be deferred until the post-war period?

This is a very broad question which has engaged our most serious attention. With more than 30 per cent of our physicians now engaged in military service, it will be obvious that the medical practitioners still in civilian life are carrying an increasingly heavy burden. To ask that depleted number to undertake the institution of a health insurance measure at this time, with its accelerated program, indeed might be asking too much.

On the other hand, it might be observed and indeed has been stated by some, that the enactment of health insurance and its implementation in the provinces during the war period might facilitate the transition to civilian life of the doctors who are now in the armed services. Under any circumstances, however, provision would have to be most carefully made in order that these doctors do not find themselves in a position of having to fight for a place in the economy of the nation.

It has been said that if this scheme were operating we could say to these men who are returning that wherever there was a population there would be an income.

It is our opinion that this whole measure should be carefully studied and that all concerned should be sure that whatever plan be adopted be sound and in the best interests of all concerned. Whatever structure is erected may prove to be the framework for health protection in this country for generations to come. Let us be sure that the foundations are carefully, firmly and wisely laid.

Finally, Mr. Chairman, we wish to say that the Canadian Medical Association desires most earnestly to co-operate with constituted authority in every possible way in sound planning for the future health services of Canada. We shall always welcome an opportunity to consult at any time with this Committee, or any committee of government, engaged in the consideration of this important subject.

The CHAIRMAN: I understand that Dr. Agnew is here also. Are there any questions the members wish to ask any of the gentlemen present?

Mr. GERSHAW: As regards paragraph 6, does that indicate that the witness would prefer doctors being paid on a fee basis rather than on a capitation basis?

The CHAIRMAN: Paragraph 6?

Mr. GERSHAW: Yes. My idea would be that doctors now on active service might easily be fettered in medical practice. It seems to me that if they come

back and find most of the arrangements signed up to doctors who are here now they will have more difficulty in establishing a practice just as do recent graduates.

The WITNESS: Mr. Chairman, it is our thought that it is quite possible that it may be found that the working out of these proposals may be so tedious that it may not be possible to get the Acts ready to operate until the end of the war, or it may be deemed advisable to say that they would not operate until the end of the war; or if it was thought to be advisable to implement them before the end of the war that these clauses which require the registration of patients with a doctor, tying up the patient with individual doctors, be made non-operative until the end of the war, except in so far as it may be necessary to have them operate that way in order to implement preventive services. You will see that if the practitioners are to be responsible for preventive services they will have to know for whom they are responsible, and to that extent it may be necessary to have people assigned to certain doctors.

By Mr. Howden:

Q. May I ask if you do not think that the setting of a panels, as referred to here, during the absence of so many doctors might result in unfairness. There is an element of unfairness not only to the doctors overseas but to many doctors here as well. It is not likely that there will be an actual distribution of all the patients to the serving doctors as we have them at present, and I think there will be a degree of unfairness?—A. That is the effect of our recommendation. We recommend that these panels, or whatever you are going to call them, be not set up until the end of the war for the reasons which have been given.

Q. Be not set up at all as far as that is concerned.—A. That is a matter for discussion. There are two lines of thought with regard to that, and it would take a great deal of time to go into the pros and cons of that particular proposal.

By Mr. Mayhew:

Q. May I ask the witness if it is his intention that industrial medicine as it is in operation in plants now would come under the general program? Your brief would indicate that it be extended.—A. There is nothing in this proposal as it is before you at the present time to exclude any group in Canada from the operation of the Act, and we endorse that position because we consider that the scheme that is before you is much broader than anything which is carried out by any industrial concern anywhere. Now, we endorse the programs that are being carried out by industrial concerns. Our point is that we recommend that they be carried out as they are being carried out now or on a more extensive scale, but under the responsibility and authority of the health insurance commission rather than under the individual initiative of individual industrial concerns.

Mr. McCANN: I would like to make a comment with regard to the section on page 6 that has to do with financial problems. "We feel, also, that the fund should not be part of the consolidated revenue of the province but should be under the complete control of the commission." Now, I do not know that I agree with that entirely. I think, as a matter of fact, it would be an advantage in having the funds that are collected go into the consolidated fund of the province because they lose their identity then and such amounts of money as are necessary for the carrying out of the provisions of the Act could be handed to the commission from time to time, and should there be occasions when there are not sufficient funds if they were earmarked just for the payment of fees, there would be sufficient funds in the consolidated revenue account to meet a condition such as an epidemic; and you are not putting a restriction on it if they are specifically earmarked and handed over to the

commission. It has another advantage too, that the commission would not be confronted with the problem, in the event of there being surplus funds, of having to make provision for the investment of those funds. Those funds could be used by the state or by the federal treasury when they are in the consolidated revenue account for such purposes as they may deem fit, and you would take the financial obligation of investing those funds from time to time away from the commission, and you would have the added assurance, in my judgment, that there would be sufficient funds at all times in the consolidated revenue account that are not earmarked and that would meet any particular situation which might arise. Perhaps Dr. Archer might like to comment on that?

The WITNESS: Mr. Chairman, Dr. McCann had two suggestions that he drew attention to. He commented on our desire that these funds should be administered by the health insurance commission. We did that because we are anxious, as we decided before, that the commission should be as independent a body as possible. He went on to say that if these funds were in the consolidated revenue account they would lose their identity, and that the consolidated revenue could supplement them if they were inadequate. Now, I cannot see anything in this bill which suggests that. If that were going to be done it would cut down one of the difficulties which we have indicated here when we said that there should be a guarantee either by a reserve or by a provincial guarantee that the fund would be adequate. We are concerned from the fact that we do not see how the adequacy of the fund is guaranteed. If Dr. McCann's interpretation is a correct interpretation it might get around that difficulty. I do not know the answer. We have said on a number of occasions that we do not consider ourselves competent to advise this committee on what the proper answer in the financial field is; we are concerned with its adequacy, and that is all.

The CHAIRMAN: Are there any other questions? Doctor, with reference to bursaries, these would, I suppose, be awarded on the basis of merit. I suppose the need would also be included in the financial need of the student?

The WITNESS: We indicate certain deserving students, and we certainly—

The CHAIRMAN: Based on the record?

The WITNESS: Except that only brilliant students would be awarded the bursaries, based on the record and the need; the two things would be taken into consideration.

The CHAIRMAN: Are there any further questions? If not, I wish to express the thanks of the committee to the Canadian Medical Association and Dr. Sclater Lewis, Dr. Agnew, and Dr. Archer for their presence here to-day.

The committee adjourned to the call of the chair.

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SESSION 1943

HOUSE OF COMMONS

SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

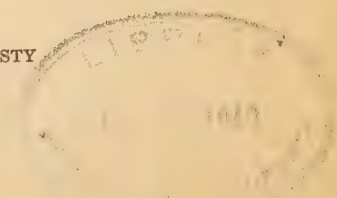
No. 25

TUESDAY, JUNE 29, 1943

WITNESSES:

Miss M. H. Hall, Acting Chief Superintendent, Victorian Order of Nurses;
Mr. T. D'Arcy McGee, K.C., Vice-President, Victorian Order of Nurses;
Mr. Grote Stirling, M.P., member of National Executive Council, Victorian
Order of Nurses;
Dr. J. Fenton Argue, member of National Executive Council, Victorian
Order of Nurses;
Mr. W. R. Creighton, Honorary Treasurer, Victorian Order of Nurses;
Mr. W. G. Gunn, Solicitor, Department of Pensions and National Health.

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1943



MINUTES OF PROCEEDINGS

TUESDAY, June 29, 1943.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Bourget, Breithaupt, Coté, Gershaw, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Lalonde, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McGarry, McGregor, Maybank, Mayhew, Picard, Shaw, Veniot and Wright—21.

The Chairman stated that he had received a letter from the Vancouver, New Westminster and District Trades and Labour Council, and this was ordered printed in the evidence.

Mr. T. D'Arcy McGee, K.C., Vice-President of the Victorian Order of Nurses, was called. He introduced the following delegates of that organization:—

Mr. F. E. Bronson, Vice-President;
Mr. W. R. Creighton, Honorary Treasurer;
Mrs. R. L. Blackburn, Convener of the Advisory Committee on Nursing;
Hon. Senator Cairine Wilson, Convener of the Educational Publicity Department;
Hon. Grote Stirling, M.P., member of the National Executive Council;
Dr. J. Fenton Argue, member of the National Executive Council;
Miss M. H. Hall, Acting Chief Superintendent.
Miss Hall was called. She presented a brief, was examined and retired.

On request of the Chairman the following delegates briefly addressed the Committee:—

Mr. T. D'Arcy McGee;
Mr. Grote Stirling, M.P.;
Mr. W. R. Creighton;
Dr. J. Fenton Argue.

The Chairman thanked the witnesses who then retired.

Mr. W. G. Gunn, Solicitor, Department of Pensions and National Health, was called. He addressed the Committee on the constitutional aspects of the draft Health Insurance Bill.

Mr. Gunn called attention to an error in the Physical Fitness Bill, clause 7, and suggested the following amendment: delete all the words following the word "census" where it last appears, and substituting the following therefor,—“or an amount equal to one-half of the moneys actually expended by such province in carrying out such plan, whichever is the less.”

In clause 9 of the same bill, 1941 should read 1931.

The witness retired and the Committee adjourned to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 29, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Gentlemen, I have received a letter from Mr. R. K. Gervin, acting secretary of the Trades and Labour Council of Vancouver, B.C., New Westminster and district, requesting that chiropractic treatment should be included in the draft bill. This letter will go on the record.

VANCOUVER, NEW WESTMINSTER AND DISTRICT TRADES AND LABOUR COUNCIL

June 21, 1943.

CHAIRMAN,
Social Security Commission,
Ottawa, Ontario.

Dear SIR.—At the last regular meeting of the above council social security and health insurance was discussed and it was pointed out that present plans do not provide for all modes of healing.

It was felt that such other methods as have proven beneficial, particularly chiropractic treatment, should be included in the draft.

Hoping you will give this matter consideration, I am,

Yours truly,

R. K. GERVIN,

Acting Secretary.

We are to have the pleasure and the honour this morning of hearing representatives of the Victorian Order of Nurses for Canada. I will ask Mr. D'Arcy McGee to introduce the representatives of that excellent order.

Mr. T. D'ARCY MCGEE (Vice-President, Victorian Order of Nurses for Canada): Mr. Chairman, Mr. Minister, members of the Special Committee on Social Security, the brief to be presented this morning for your consideration is submitted by the Victorian Order of Nurses for Canada. Unfortunately, our president, the Hon. Mr. Justice Davis of the Supreme Court of Canada is unavoidably absent owing to illness and as one of the vice-presidents I have the honour and the pleasure of introducing our committee. We have another vice-president, M. F. E. Bronson, who is here this morning, and there are also Mr. W. R. Creighton, honorary treasurer, Mrs. R. L. Blackburn, convener of the advisory committee on nursing, Senator Cairine Wilson, who will be here later, she has advised us, and who is convener of the educational publicity department; and the members of the national executive council present here to-day are the Hon. Grote Stirling, M.P., and Dr. J. Fenton Argue of Ottawa.

Mr. Chairman, the brief will be presented by the acting chief superintendent, Miss Hall.

The CHAIRMAN: Thank you, Mr. McGee. Miss Hall, please?

MISS MAUDE H. HALL called.

The WITNESS: Mr. Chairman, Mr. Minister, and members of the Committee on Social Security:—

The Victorian Order of Nurses for Canada is a national voluntary health organization which was established in 1897 by a Royal Charter. In July, 1929, revision of the constitution was made under a Canadian Charter through the Department of the Secretary of State, to broaden the objects of the organization to conform with modern developments in public health work. The Victorian Order offers a skilled visiting nursing service to patients in their own homes. The fee charged is reasonable. It is set merely to cover the cost of the visit and may be adjusted downwards to suit the family's circumstances. No case is refused because of inability to pay.

It is a service for all regardless of race, creed or financial status. It exactly meets the needs of those patients who do not require or cannot afford full time nursing care, as well as of those who for various reasons cannot or need not enter hospital. All calls are answered but nursing care is continued only under the direction of a physician.

Care is given to medical, surgical and maternity patients, and advantage is taken of the many opportunities to integrate the teaching of health measures in the visit for nursing care. Public health services including school nursing, child welfare centres, assistance at immunization clinics and group teaching are undertaken in many communities where they are not provided by an official organization. In two centres a nursing service is extended to the employees of local war industries.

There are ninety-nine branches of the order. These are distributed in eight of the nine provinces:

Nova Scotia.....	16	Manitoba	1
New Brunswick.....	7	Saskatchewan	3
Quebec	5	Alberta	2
Ontario	55	British Columbia	10

During the war years, eleven new branches have been organized and seven branches have extended the territory served beyond the city and town limits to suburban and township areas.

Branches are scattered throughout Canada from coast to coast. They enjoy local autonomy but accept the policies and professional standards of the national office. All branches are visited twice a year by national office supervisors to ensure uniformly high standards of service. There is direct contact between the national office and the local branches.

The ninety-nine branches of the order are maintained by local boards composed of representative citizens. The branches are supported by means of fees from patients, fees from insurance companies for service to policyholders, membership fees, municipal and township grants and additional money-making efforts on the part of local boards. Twenty-three branches are members of community chests. Local representatives largely constitute the membership of the national board of governors from which the executive council of the Victorian Order of Nurses for Canada is appointed. The branches do not make any contribution towards the support of the national office, but financial assistance is given the branches when the need is indicated and 1942 was the first year for

many years when such aid was not needed by any branch. In British Columbia grants are made by the provincial government on a per capita basis for the nurses employed. In Saskatchewan payment is made by the provincial government on a visit basis for care to indigent patients who are temporarily in the area served. The Winnipeg branch receives a grant from the Manitoba government. The Ontario Department of Health does not contribute to the support of the individual branches but makes a grant to the national organization in recognition of the supervisory service provided. In New Brunswick the Department of Health makes a grant to those branches giving a school nursing service. One branch in Nova Scotia receives assistance from the provincial government.

A staff of three hundred and eighty-seven nurses is employed. The national office supplies the nurses to the branches, recommends salaries paid locally and is responsible for the type of service rendered. The standard of preparation is high. Registration in the province in which they are working and in addition to hospital training, a year's post-graduate study in public health nursing is required. But in the face of a large turnover in staff and the present shortage of public health trained nurses due to the demands of the war effort, the expanding public health services and the increased number of marriages, we have had to make some concessions. In order to fill our vacancies we are employing some nurses who have not had the required public health course, in a junior capacity. Their employment is on a temporary basis and many of them are planning to comply with our requirements as soon as financial resources permit.

This year the Victorian Order is awarding twelve scholarships to assist nurses to take a university course in public health nursing with the purpose of increasing the number of well prepared nurses available for Victorian Order work.

During 1942 Victorian Order nurses made 723,145 visits to care for 88,646 patients—47 per cent of the visits were classified as morbidity. Of these, 7,138 were to patients with pneumonia; 3,386 to patients with tuberculosis; 8,084 to patients with other communicable diseases; 27,729 to cancer patients; 88,168 to chronic patients; 192,636 to patients with other medical and surgical diseases. Assistance was given at 1,073 home operations.

Although the trend is toward the hospitalization of maternity patients, the care of mothers and babies continues to be a major function of Victorian Order work. Last year 45 per cent of our visits were made for care and instruction during the maternal cycle. Victorian Order nurses made 46,441 visits to expectant mothers to teach the hygiene of pregnancy. They assisted the doctor at 6,496 home confinements and made 236,626 visits to give nursing care and health supervision to mothers and newborn infants. Due to crowded conditions, mothers and babies are being discharged from hospital before the eighth day which was formerly considered the minimum period of hospitalization after childbirth, and care is frequently needed after the return home and even where the stay is prolonged to the eighth day the young mother needs advice and assistance in establishing a routine for the care of the baby.

Over a period of years the group of mothers and babies under Victorian Order care and supervision have shown markedly lower death rates than the rates for Canada. (See statement attached.)

In the present emergency when a proper distribution of nursing service would probably eliminate luxury nursing and hospital accommodation is strained to capacity the more widespread use of the service of the Victorian Order nurses would release many hospital beds for cases needing this type of care. Home nursing care on a visiting basis enhances the value of the individual nurse and

distributes nursing care more in accord with the patient's needs. An extract is attached which expresses appreciation of the usefulness of this service to a community and its economic value.

The Victorian Order has for some years made arrangements to sell service on a visit basis. A working arrangement exists with the Metropolitan Life Insurance Company whereby service is supplied to their policyholders. This arrangement is made through the national office. A similar plan (but on a smaller scale) has been worked out with the Women's Benefit Association and the Maccabees and with the Aetna Life, Confederation Life, London Life, Sun Life, and Travellers Insurance companies for their group policyholders.

These contracts not only offer additional opportunities for service in the homes but are of assistance financially to the local Victorian Order services. One definite result of these contractual relationships is that a standard method of cost accounting for services rendered has been established. From year to year, costs inevitably vary depending on the community served, the density of population, travel time, transportation facilities, extent of hospitalization and type of work undertaken. They are estimated annually in each centre and submitted to the national office. The average cost per visit in 1941 was 93.3 cents. (Returns for 1942 are not yet complete.)

A booklet is attached giving information regarding the services and organization which may be of interest.

The national office is supported by means of government grants, interest on endowment funds and individual subscriptions.

As a voluntary organization, it is recognized that the Victorian Order has a definite responsibility to the official health departments, national, provincial and local. Consequently its aim is to give the fullest possible co-operation to these departments and to work in closest harmony with other health and social agencies throughout Canada.

The Victorian Order is a service organization with over forty-five years' experience in this type of work, possessing the machinery yet without adequate means to extend the work to the extent it is needed. Under a plan of health insurance providing domiciliary nursing service the Victorian Order would have something concrete to offer.

All of which is respectfully submitted.

T. D'ARCY McGEE,
Vice-President.

MAUDE H. HALL,
Acting Chief Superintendent.

June 29, 1943.

VICTORIAN ORDER OF NURSES FOR CANADA

MATERNAL DEATH RATE

<i>Year</i>	<i>Dominion</i>	<i>Victorian Order</i>
1938	4.2	1.5
1939	4.2	2.0
1940	4.0	1.7
1941	3.5	1.3
1942	3.0 (tentative rate)	1.2

NEONATAL DEATH RATE

<i>Year</i>	<i>Dominion</i>	<i>Victorian Order</i>
1938	32	19.45
1939	31	13.8
1940	30	13.9
1941	31	14
1942	28 (tentative rate)	11

NUMBER OF OBSTETRICAL CASES ATTENDED BY VICTORIAN ORDER

1938	11,256
1939	17,308
1940	18,349
1941	19,281
1942	20,141

ANALYSIS OF WORK FOR 1942

Total Cases	88,646	
		Per cent
Morbidity	41	
Maternity	51	
Health Instruction	8	
Total Visits	723,145	
		Per cent
Morbidity	47	
Maternity	45	
Health Instruction	8	

CLASSIFICATION OF VISITS ACCORDING TO PAYMENT

	Per cent
Paid	15
Part Paid	18
Free	54
Paid by Insurance Companies.....	13

Extracts from address given by Dr. G. M. Little, Medical Officer of Health of Edmonton, at the Annual Meeting of the Victorian Order Local Branch in that city. (1938)

"The value of the service to those who receive it is an obvious one, but the place which the organization occupies in the economy of the community is not so widely recognized. Such nursing service in the home releases many hospital beds and those of you who are aware of the present crowded condition of our city hospitals will recognize the importance of this to the community. Furthermore, many of these patients who would otherwise require hospitalization, would have to be given such care at the expense of the municipality. It is conceivable that many municipalities might eventually be driven to organize bedside nursing services on an extensive scale to conserve costly hospital accommodation. So that, aside altogether from humane considerations, the Order occupies an important place in the economic welfare of our community.

"The medical profession has agreed to the need of some type of health insurance to facilitate the distribution of medical services to many of our people.

"The interest in many quarters evinced by people themselves in this problem suggests a widespread desire for some more organized manner of assuring the best of care for themselves and their families when sick, regardless of their station in life.

"I am not going to discuss at the present time the merits of the various schemes which have been suggested; but with the weight of opinion which is evident among so many of our people, I am sure that the day when some such scheme will be tried is not far distant, and I think that it is high time that all we who are interested in and responsible for control and the care of sickness in our country should be applying our minds to working out a solution, so that when the time arrives a practicable plan may be available.

"When this time comes, and I am sure it will come, with its increased demand for hospitalization as has been found in the insurance scheme in England, one of the most urgent demands, and indeed one of the most necessary financial safeguards, will be a great increase in just the type of service which is now being delivered by the Victorian Order. I believe that you will be called upon to assist in evolving such a plan, contributing the experience which has been and is being gathered by the Order."

The CHAIRMAN: Are there any questions for Miss Hall? Miss Hall, on page 4 where you speak of the assistance given to doctors at 6,496 home confinements and 236,626 visits to give nursing care and health supervision to mothers and newborn infants, would those cases be both urban and rural?

The WITNESS: Mr. Chairman, they would be largely urban, but as I said elsewhere in the brief some of our branches have extended into township areas, and we have one definitely rural centre.

By Mr. Lalonde:

Q. Miss Hall, on page 5 you say: "Under a plan of health insurance providing domiciliary nursing service the Victorian Order would have something concrete to offer." I think the committee would be very much interested to know what concrete proposition the order have to offer within the scope of the prospective bill?—A. Mr. Chairman, under the present bill, I understand that home nursing services will be provided, and wherever the Victorian Order is organized the branch would be in a position, I think, to give that nursing service at a reasonable rate—at as reasonable a rate as could be provided in any other way—and also the assurance that the service given is a supervised service. In centres where we are not organized at the present time that would present a difficulty. The one point is that there might be the possibility of more extensive organization. Does that answer your question?

Q. Yes, thank you very much.

By Mr. McGarry:

Q. On page 3 at the bottom of the second paragraph you say: "In order to fill our vacancies we are employing some nurses who have not had the required public health course, in a junior capacity." Does that mean that they have taken their hospital training but have not taken their post-graduate course?—A. Yes, they are all registered nurses, fully trained registered nurses.

Q. But they have not taken a course in post-graduate nursing?—A. Yes.

By Mr. Lalonde:

Q. On page 2 you state that there are ninety-nine branches of the order all over Canada. I should like to know in which cities these branches are located,

and more particularly in the province of Quebec, because I understand that your order has five branches in Quebec, and I should like to know where those branches are located and how they work in the province of Quebec?—A. In the province of Quebec, as stated in the brief, there are five branches which are located in Montreal, Lachine, Sherbrooke, Pointe Claire and in Ste. Anne de Bellevue.

The CHAIRMAN: Mr. Lalonde, do you wish the names of cities elsewhere?

Mr. LALONDE: Yes.

The WITNESS: Nova Scotia: Amherst, Bridgewater, Canso, Dartmouth, Digby, Halifax, Kentville, Liverpool, Lunenburg, New Glasgow, Pictou, Sydney, Truro, Windsor, Wolfville, Yarmouth;

New Brunswick: Campbellton, Fredericton, Moncton, Newcastle, Sackville, Saint John, Woodstock;

Ontario: Arnprior, Barrie, Peterboro, Border Cities, Braeside, Brampton, Brantford, Brockville, Burlington, Carleton Place, Chatham, Cobourg, Cornwall, Dundas, East York—that covers a township—Galt, Gananoque, Guelph, Hamilton, Huntsville, Kingston, Kirkland Lake, Kitchener, Leamington, London, Napanee, New Liskeard, North Bay, North York—which is also a township—Orillia, Oshawa, Ottawa, Owen Sound, Pembroke, Peninsula—which covers a number of places including a township in Niagara peninsula—Peterboro, Porcupine, Preston, Sarnia, Smiths Falls, St. Catharines, St. Thomas, Stratford, Sudbury, Timmins, Toronto, Trenton, Waterloo, Welland, Weston, Whitby, Woodstock, York Township;

Manitoba: Winnipeg;

Saskatchewan: Prince Albert, Regina, Saskatoon;

Alberta: Calgary, Edmonton;

British Columbia: Burnaby, Elphinstone, Oliver, North Vancouver, Surrey, Trail, Vancouver, Victoria, Westbank, and West Vancouver.

I may say, with regard to Ontario, that a new branch has been organized in Niagara Falls. That is not mentioned here.

By Mr. Howden:

Q. Mr. Chairman, I would like on rising to express my appreciation of the work done by the Victorian Order of Nurses. I very well remember when I was a young medical man in the city of Winnipeg the very able and excellent assistance I got in many instances from the order. I am wondering, for that reason, why we have only one branch of the order in Manitoba. I am sure that the branch we have in the city of Winnipeg is a very active and excellent branch and is used, shall I say, very steadily. I know that they are tremendously busy. I am wondering, therefore, why such cities as Brandon and Portage la Prairie, and other places I could mention, are slighted in this manner, because I believe that the Victorian Order fills in a need that is served by no one else, and I am curious about that matter.

The CHAIRMAN: Perhaps Mr. McGee would care to comment on that question?

Mr. MCGEE: I think Miss Hall is more familiar with the practice than I would be. Up to now she has done a very good job and I will leave it with her. I might only throw a monkey-wrench in the machine.

The WITNESS: Mr. Chairman, I may say that the Victorian Order has not had any aggressive policy in organization; they have rather confined their efforts to places requesting the service of the order. We also have done a certain amount of publicity to encourage places to ask for service. As far as Manitoba is concerned we have done some work in that regard; preliminary work on organization was done in Brandon, but it did not carry through for some reason or other. We have felt in the past that where we could encourage communities

to ask for service we organize on a sounder foundation than when we went in and rather urged the organization on the community; whether we were right or wrong in that regard I am not in a position to say.

By Mr. Howden:

Q. There has been no request from these other cities?—A. Not in recent years; I do not know about the past.

By Mr. Wright:

Q. On page 4 I find the following:—

The Victorian Order has for some years made arrangements to sell service on a visit basis. A working arrangement exists with the Metropolitan Life Insurance Company whereby service is supplied to their policyholders.

I note also that the arrangement has been made with various other companies. I am wondering if there would be any objection to having placed on the record the financial arrangements with these companies?—A. Well, I may say the arrangement with the company is that the company will pay at the rate of the cost per visit or a fee charged for visits made to the policyholders of the company.

By Mr. Johnston:

Q. Is that fee rate constant for all companies or are there different rates for different companies?—A. No, it is one rate, because it is based on the cost per visit, but in different areas it varies a bit according to the cost of the visit in those areas.

By Mr. Shaw:

Q. On page 1, Miss Hall, I find the following: "In two centres a nursing service is extended to the employees of local war industries." That is, I suppose, by arrangement with the management of the plants?—A. Yes.

Q. Have you had requests from more than two centres for such a service?—A. We have requests from one or two centres in addition to those under consideration at the present time, but they are just coming in.

By Mr. Breithaupt:

Q. Kitchener and Waterloo have been pioneers, I believe, in this work. I know very well the benefits that are derived from the work of the Victorian Order and the splendid work they are doing in these centres. I was wondering if there was some plan under consideration whereby an extension of the work may be made available to other communities which at the present time do not enjoy this splendid service. Is there any plan or any central committee appointed to expand the work in other cities? For instance, in Quebec the number of Victorian Order organizations is very small, and the same applies to other provinces. Is there any central organization working on expansion?—A. We have a committee on education and publicity which also has under its duties the planning for possible extension; some years ago we put on a definite campaign for extension and offered a grant divided over a period of three years to communities for organization, and we did organize at a very rapid pace during that time. Due probably to limitation of funds and also to some extent limitation of staff, that was not pursued; but in the last few years we have been organizing a certain number of branches each year but not as extensively as we could do. I think during the three years we probably would have done more than we did, but there is that scarcity in the supply of public health nurses, and we have a great deal of difficulty in obtaining nurses for the branches that we did open. However, after the war that problem probably will not present itself.

Mr. McGEE: May I say also the convener of the committee, known as the Education and Publicity Committee, is the Hon. Senator Cairine Wilson. That committee is doing very excellent work in that respect.

By Mr. Howden:

Q. The last sentence of the submission is as follows: "Under a plan of health insurance providing domiciliary nursing service the Victorian Order would have something concrete to offer." I was just wondering if Miss Hall would care to amplify that statement; that is to say, is the suggestion that the Victorian Order will continue to serve the public of Canada in precisely the same way as in the past or is it the suggestion that there be an agreement between the order and the security service of Canada?—A. Well, it is understood that under the plan of health insurance—it would perhaps vary in the different provinces—the suggestion is that the Victorian Order is in a very good position to offer a home nursing service to the various communities in which the order is organized at the present time, and there also would be the possibility that the Victorian Order might make some further extension to communities where it is not at the present time organized, especially such time after the war when more nurses with training that we require would be available for positions. Of course, we are in the position of being limited by the funds that we have at our disposal.

Q. The idea is you will continue the service you are rendering at the present time and enlarge it? Do I understand that is the correct interpretation?—A. That is what we would wish to do, but of course it would depend on the set-up and the circumstances, but as far as we can see at the present time we see that we can play a useful part in such a scheme.

By Mr. Bourget:

Q. Can you tell us if your association has any relation with the other organized associations of registered nurses in Canada or in any province?

The CHAIRMAN: Will you repeat that, Mr. Bourget?

By Mr. Bourget:

Q. Can you tell us if your association has any relation with the other organized associations of registered nurses?—A. Now, do you mean with other nurses doing public health nursing or—

Q. Yes.—A. Yes—well, we always feel that wherever we organize we are a part of the local public health program and as such should co-operate in every way with the other nurses doing work in the community. We also feel that we are to quite an extent under the direction of the medical officer of health in that community and any program that we enter into we do with his approval and consent.

By Mr. Shaw:

Q. I note from the brief that the Victorian Order require a year of post-graduate work in public nursing. Are you able to offer definite compensation which will attract nurses to take the year's post-graduate work? Are the salaries higher in comparison with what nurses are paid in the hospitals, or do you depend upon probably inducing them to take up the work because of the valuable service which you are performing?—A. Mr. Chairman, I think in the brief it was stated that the national office recognized the salaries for nurses placed locally, and we have a schedule of salaries which was arrived at after a good deal of consideration and also consideration of salaries that are being paid other public health nurses.

Q. How would they compare with salaries paid to nurses in the hospitals?—A. I think they would probably compare favourably with those paid for nurses

on general duty; but, of course, for many of the positions in hospitals special training is also required and we rather consider them on the basis of nurses doing other public health work.

By the Chairman:

Q. I notice you have no branch in Prince Edward Island; is that because no request has been made?—A. Mr. Chairman—

Q. I was just thinking of the old hymn that "Ninety and nine were safely laid in the shelter of the fold..."—A. We wish that it were one hundred.

Mr. McGEE: You have prohibition down there.

By the Chairman:

Q. They do not need assistance?—A. I have visited the province of Prince Edward Island a number of times because there was interest down there, but the province is not large and they have—while it may not be a home nursing service—they have a plan of public health nursing that rather covers the province and up to the present time they have not seemed to feel the exact need.

The CHAIRMAN: Mr. Stirling, would you care to add anything to the remarks that have been made?

Hon. Mr. STIRLING: Mr. Chairman, merely to register for my province here to-day the keen interest I have taken in the Victorian Order for many years now, largely due to the fact that there are two branches in my constituency. It is, of course, rural work, not city work, and I know a good deal of the arduous work that the resident nurse has to undertake in a widespread community and the excellency of the work that is done. A certain amount of work is carried out by the nurses in co-operation with the care of Indians and for a good many years the order has endeavoured to keep in closer co-operation with the superintendent of Indian affairs. We still hope that there may be opportunities for expanding that work. A year or so ago I was honoured by being elected on the council and that is the reason why I am present here to-day.

The CHAIRMAN: Thank you, Mr. Stirling. Would any of your associates, Mr. McGee, care to comment further?

Mr. McGEE: Thank you, Mr. Chairman. I think all we have to say or nearly all we have to say has been submitted by Miss Hall.

The CHAIRMAN: Would Dr. Argue care to say a word?

Dr. J. FENTON ARGUE: Mr. Chairman, —

Mr. McGEE: These doctors will talk, you know.

Dr. ARGUE: Mr. Chairman, I have very little to add except to say this, the Victorian Order of Nurses was organized just about the time I started to practice medicine, and I have watched its expansion. I have profited by the services of the Victorian Order in this city and I have observed the work that is done in other cities, particularly in smaller cities where a trained nurse is not always available. I am interested in this work and I am heartily in accord with the brief as presented; and when we do get our social security Act I feel that there will be a niche for the Victorian Order to work in a more extended area than they are doing at the present time.

Mr. W. R. CREIGHTON: Mr. Chairman, as one of the joint honorary treasurers of the order I have sensed that the questions this morning are very pertinent as to why there are not more branches of the Victorian Order. It seems to me that can be answered very briefly; that we are limited by our funds which we have on hand and the contributions; secondly, we are limited by the number of available nurses, but primarily we have to depend on a local urge, someone has to want the services in the locality. If they come to us we investigate that

locality and I do not know of many of those requests that have not been serviced in recent years. We have not all the funds we want, but we have gone out of our way to dig into our reserves very materially in order to establish new branches in the last four years. In fact, one of the requests which was made for funds was for the purpose of extension. We would like to extend further, but we have those two limitations. However, in the final analysis it comes to this, the work of the local committees, the people in the local places who feel the service is needed, people who know the Victorian Order gives good service and who will come to us and try to work out the problem both financially and in respect to the supply of nurses.

The CHAIRMAN: I am sure we all agree with Dr. Howden's words of tribute to the Victorian Order of Nurses, and on behalf of the committee I thank Mr. McGee and his associates and especially Miss Hall for a very excellent presentation. Thank you very much.

Mr. McGEE: Thank you, Mr. Chairman and gentlemen for your kind consideration this morning.

The CHAIRMAN: We shall now call on Mr. W. G. Gunn, solicitor for the Department of Pensions and National Health, who will speak to us on the constitutional aspects of the draft social insurance and health bill.

Mr. W. G. GUNN, Solicitor for the Department of Pensions and National Health, called.

The WITNESS: Mr. Chairman, Mr. Minister and members of the committee, as departmental solicitor I have had something to do with the drafting of this bill, that is, putting the proposals of the advisory committee into the form of a draft bill and I hope that I may be of some assistance to your committee in your consideration of it.

Before dealing with the constitutional aspects of the situation may I just digress for a moment, Mr. Chairman, to observe that Mr. A. D. Watson, one of the members of the Advisory Committee, in his statement before this committee in its opening sessions was either exhibiting his characteristic modesty or, with natural caution, disclaiming liability, in suggesting that the drafting of this bill was almost wholly mine. The fact of the matter is that Mr. Watson's experience, his knowledge of insurance generally, his familiarity with social insurance and social assistance in other places, and his uncanny foresight on problems which are likely to arise in administration, were invaluable, not only in drafting, but throughout all stages of the work of the Advisory Committee.

Now, as to the constitutional aspects of the bill, these, of course, were considered by me before drafting was commenced. I then came to the conclusion that it was safe to proceed along lines of dominion aid to provinces. Those lines were accordingly followed. I would have been remiss in my duty if, since that time, I had acquired any doubts as to the general soundness of this legislation and did not express those doubts. I hold the view that while constitutional flaws may possibly be discovered in some provisions of the bill, there will be none that cannot be cured by redrafting the particular provisions. The draft bill is at present before the Department of Justice for study, and apart from three or four clauses, some of which may have to be redrafted and others omitted entirely, no major fault has been found with it. A further report from the Department of Justice may be expected any day.

Mr. Chairman, it has long been recognized that in so far as public health and insurance are concerned, these matters are almost entirely within the jurisdiction of the provinces. This view was definitely confirmed by the reference to the Supreme Court in 1935 of certain legislation passed by the parliament of that time which included the Employment and Social Insurance Act. The Supreme Court, as you will remember, denied the validity of that Act as trench-

ing on matters of provincial concern (1936 S.C.R. 427), and that judgment was confirmed by the judicial committee of the Privy Council. It may be pertinent to observe at this time that every province has dealt exclusively with those subjects of health and insurance in the local field, and as respects health, each province has built up considerable machinery and developed a skilled personnel to deal with matters relating to public health in the province.

The Advisory Committee on Health Insurance, having those considerations in mind, developed a plan of national compulsory health insurance along the already well tried lines of Dominion and provincial co-operation. They make no apology for recommending that approach for the reason that the present co-operation between the dominion and the provinces can easily be increased, developed, and extended into the fields of health and insurance. The dominion bill, therefore, would enable the dominion to enter into an agreement with any province whereby the dominion would make annual grants to the province for certain purposes. These purposes divide themselves into two classes. The one relates to the maintenance, improvement, or extension of ordinary public health services now existing and being carried on by the province, and the other relates to the introduction and operation by the province of a health insurance plan satisfactory to the dominion. A grant cannot be made for one purpose without a grant being made for the other.

The conditions of grant relating to public health are of a general character and can be found set out concisely in the first schedule to the bill. It will be found, in the case of most provinces, that most of these conditions are already in existence and the only concern that the dominion would then have in them is that they be maintained and, if necessary, extended, so as to ensure co-ordination with health insurance services. The other conditions are those relating to health insurance, and being new and being important, as forming the basis of any agreement made with a province, it was felt that these must be provided for by a special statute of the province. Consequently, a draft provincial health insurance bill has been prepared and becomes the second schedule of the dominion bill. It is a guide to the provinces as to dominion requirements, but it does not need to be enacted in the precise form or language of the draft—only substantial compliance is required. (See Clause 4.)

The annual grants for public health services generally are to be a definite percentage, fixed by the Act, of the amounts expended by the province annually in carrying on those services, but the grants for health insurance are to be made on a per capita basis. The amount will be fixed as a definite part of the per capita cost of health insurance after such cost has been estimated as closely as possible and agreed to by the parties to the agreement. Needless to say, these grants only continue for so long as the dominion continues to be satisfied that the province concerned is living up to its agreement in every respect.

The dominion bill also provides for administration of its terms by the Department of Pensions and National Health and the establishment thereunder of a National Council on Health Insurance consisting of the Director of Health Insurance for the dominion, the Deputy Minister of Health of each province, having an insurance plan, the chief administrative officer of health insurance of each province, and representatives of various organizations primarily concerned, such as labour, agriculture, women's organizations, and the professions which are to supply the services. These persons, other than the dominion government officials, are appointed by the Governor in Council.

Provision is made for receipt by the Minister of Pensions and National Health from the provinces of current and annual reports and also for the submission by him to parliament of an annual return which will include complete information as to operations during the past year and will include copies of all regulations made under the Act during that year.

Now, dealing particularly with the draft health insurance Act, that is the provincial bill, the draft bill provides for the receipt of health insurance benefits by all persons who have their normal place of residence in the province.

The cost of providing these benefits is met partly from contributions paid by or on behalf of insured persons and partly by the dominion grants.

The contributors to the scheme can be roughly divided into employed persons and assessed persons. "Contributors" does not include children. That does not mean, however, that children are not entitled to the benefits of insurance. The principle of the bill is that in fixing the proper contribution for adults it will be fixed sufficiently high to take care of the cost of providing the benefits for the child population of the province. Dependants of a contributor, other than children, shall be paid for by that contributor, either in full or in proportion to the degree of dependency, and having regard, also, to his ability to pay.

In order to have a complete record at all times of persons qualified to receive benefits, the draft bill provides for registration of such persons. A further purpose of such registration is to enable the insurance authority, which in this draft bill is a commission, to assess all persons, other than employed persons, in order to determine whether such persons shall pay the whole contribution by themselves or have that contribution or part of it paid by the province. In order to obtain this registration, the bill provides that every person resident within the province, other than employed persons, shall, whenever called upon, but not oftener than once a year, file a return with the Commission in the form prescribed. This form will contain information as to the income and property of such person.

As to employed contributors, their contributions shall be deducted, in accordance with the rates fixed, by the employer on each pay-day and by the employer forwarded to the Commission. If the employee is not in receipt of sufficient wages to provide, at the rate fixed, the whole contribution, the employer must provide the difference himself. As to assessed persons, these will consist of persons who are not employed for wages or salary or similar remuneration, and their contributions will be determined by the income and property shown by the annual return. In case there may be any doubt on the point, I ought to say at this stage that the draft bill contemplates, as the annual contributions of all persons, a fixed percentage of their income with a limit of a certain amount which has been determined by the Commission to be sufficient to pay the cost of that insurance, or, in the case of persons in the lower income groups, such amount as to the Commission seems equitable.

Provision is made in the draft bill for ascertaining the income of persons who are not wage-earners, and defining, of course, the method for fixing the contribution of those who, on account of limited income, are found to be unable to pay in full. It has already been pointed out that while the annual return provides for a complete listing of income and property, the person completing the return does not need to list his property or income if he is satisfied by reason of the amount thereof that he must pay the contribution in full. He has the alternative of sending in the return without those particulars, and remitting at the same time the full amount of his contribution.

As to any assessed persons, i.e., persons who are not wage-earners, if it is found that their income and property are not sufficient to warrant the payment of the full contribution they will be required to pay only a proportion of that contribution to be determined from the relationship of their actual income to the maximum income required to produce the standard contribution. Any difference will be paid by the province. You will see, therefore, that the Commission may take care of cases of indigency or near-indigency without any special provision in the Act to cover such cases. In fact, the framers of the draft bill have studiously avoided the use of the word "indigent" throughout.

I do not need to dwell on the subjects of assessment and contribution for Mr. Watson has already explained the operation of the bill with respect to those matters in his memorandum tabled at the sittings on the 19th of March (paragraphs 15 to 28 inclusive).

The bill provides for the setting up of a Health-Insurance Fund into which will go all moneys received from contributions from or for insured persons and grants from the dominion as well as any moneys payable by the province. The Fund will be operated by the Commission subject to the provisions of the Act and moneys will be payable out of it on requisition of the commission to the provincial treasurer.

As to benefits available under the plan, those have been made as liberal and comprehensive as possible and are to be supplied uniformly to all parts of the province. No distinction is made between urban and rural areas, but the Commission is allowed by a special "escape" clause in the Act (33 (3)) to vary or modify the scheme in remote areas and to bring to those areas such benefits as may be reasonably practicable. But in order to correct any impression to the contrary, I want to emphasize that for all organized rural communities the whole scheme of benefits is intended to apply in the same manner and to the same extent as it will apply in highly populated urban districts. The benefits include medical, surgical, and obstetrical benefits (including the services of specialists and special treatment), pharmaceutical, nursing and hospital services. As to dental services, these shall be such as may be within the capacity of the dentists of the province to supply. They may have to be limited to children for a start.

All these benefits are made available throughout the province through arrangements to be made with the professions or services concerned and subject to well-established principles of practice. The arrangements which are made in any case become regulations and as such become part of the working machinery of administration.

As I have already indicated, the bill provides for administration by a Commission. The committee chose this particular type of administration for reasons which have already been stated, but the Committee is not definitely committed to this particular type of administration and realizes that it may not be found to be suitable in some cases. However, the machinery that has been set up for the Commission could be easily adapted to administration under a public health department of government if such is desired in any or all of the provinces. The Commission may be of any size but the present bill contemplates a commission consisting of several persons, the chairman being the only permanent salaried administrative officer. The whole Commission would meet only occasionally and deal with problems and make regulations in somewhat the same manner as Parliament meets to consider the state of the country and to make laws. All regulations passed by the Commission would be subject to the approval of the Lieutenant-Governor in Council and, of course, would have to be consistent with the terms upon which dominion assistance is being given.

The bill provides for the division of the province into health insurance regions which shall coincide with public health regions. It is hoped thereby to facilitate the integration of the activities and machinery of the Public Health Department in the health insurance scheme.

Then the bill provides for determination of various questions affecting administration and for the investigation of disputes in a short, simple manner. There is, however, provision for appeals from decisions given by the committees concerned and an ultimate appeal to the courts in certain important questions effecting the rights of individuals. There is, further, provision for inspection of all services connected with the administration of the Act and provisions creating offences and defining legal proceedings generally. All these matters can be further dealt with by regulation.

An important feature of the regulations which may be made under this proposed Act is that they may be broad enough to cover any point upon which

the Act is silent. Of course, all regulations are subject to the approval of the Lieutenant-Governor in Council and as I have stated before, must not conflict with or impair the terms of the agreement made between the province and the Dominion.

In my remarks up to this point I have dealt with jurisdictional aspects to a greater or less degree but now, Mr. Chairman, with your permission, it might be useful for me to touch very briefly on one or two questions that have already been the subject of discussion or submission before this Committee, questions which are but remotely related to jurisdiction.

One of the most important of these is the form of administration to be used in the provinces. The provincial health officers of the various provinces have already expressed themselves in favour of administration under the departments of health, or as an alternative or second choice, of a commission controlled by that department, in each case with an advisory committee on health insurance. That is one side of the question. The other side, the insistence on a commission form of administration, has likewise been presented. Whether your committee is going to pronounce in favour of one to the total exclusion of the other, I do not know, but it is obvious that if the Dominion government should insist on a particular form of administration which turns out to be not acceptable to a province, then health insurance with Dominion aid cannot be achieved in that province. The advisory committee had that in mind; they had to put forward some working machinery for consideration by the provinces, but endeavoured to make the bill sufficiently flexible to meet any reasonable provincial requirements. Clause 4 of the Dominion bill provides that the provincial health insurance legislation shall be in terms set forth in the draft provincial Act (second schedule) "or substantially in the terms aforesaid, or in such terms as, having regard for all the circumstances, for the special conditions affecting the province as a whole, or any special areas in the province, may be accepted by the Governor in Council as a satisfactory practical measure of health insurance for the province." As a lawyer, I express the opinion that such language is broad enough to take care of the form of administration. That is not "of the substance" of the insurance plan.

To allay any fears of the provincial health officers as to results of administration by commission, I might point out that the Commission described in the draft bill

- (a) is appointed by the Lieutenant-Governor in Council (35(1)).
- (b) has a chairman who is to be a doctor of medicine (35(2)).
- (c) includes the provincial health officer as an ex officio member. (35(3)).
- (d) provides for the chairman to be the Chief Executive Officer. (36(1)).
- (e) must have its regulations approved by the Lieutenant-Governor in Council. (56(3)).
- (f) will be compelled by law to co-operate with the public health authorities in the interest of public health. (42(2)).
- (g) must submit its annual report to the Minister of Health. (57 (1)).
- (h) must make any approach to the government through the Minister of Health. (59).

From the foregoing there would seem to be a large measure of governmental and departmental control of the Commission. It may be pointed out that no serious objection could be taken to the provincial government imposing further controls if deemed advisable.

But again let me emphasize that I hold no brief for administration by commission, especially if such administration involves any great departure from the principles of responsible government.

Another question raised the other day had to do with the inclusion or exclusion of schemes of insurance now being operated by industrial and commercial organizations. It is not within my province to deal with such a question if it

should be a matter of policy. I do say, however, that the bill contemplates that all persons within the province shall be covered by its provisions, and it also contemplates that all existing facilities be brought into use in order to carry the benefits of preventive health services and insurance against sickness to the people. Again, these things are of provincial concern. Those who decide on such matters as excluding private health insurance plans will require to do the following, among other things:—

- (a) Make a detailed analysis of the benefits of the several private insurance plans and compare those benefits with the benefits being offered by the public plan.
- (b) Compare the cost of those benefits with the cost of those being provided by the public plan.
- (c) Ascertain the freely-expressed opinion of the beneficiaries of the private plans.
- (d) Consider the financial responsibility of the sponsors of such private plans and the continued financial stability of such plans.
- (e) Consider the immediate and future effect of private plans on the public insurance financing.
- (f) Judge as to the value of any such private plan as part of a general plan looking towards the curtailment and ultimate elimination of many diseases.
- (g) Decide if any facilities or personnel of any such private plan can be economically used in the furtherance of a general plan.

Similar considerations will apply in a greater or less degree to sickness and accident companies being operated for gain, or being operated on a mutual non-profit plan as in the case of fraternal and similar organizations.

Another question upon which there seems to be a little misunderstanding is with respect to the committees representative of the professions and the hospitals in the province. I may point out that under the terms of this bill there is no legal obligation upon the commission to recognize any committee, even if it does satisfy the commission that it has the qualifications mentioned, namely, that it is representative of, and authorized to speak for, the profession concerned or for hospitals, as the case may be. The language of the bill is purely permissive but, of course, the province when enacting the statute may use mandatory terms if it desires. There is, however, such an obligation imposed by the bill upon the commission with respect to committees appointed by dentists and druggists who claim to have in every province a representative organization created by or virtue of a statute. In any case this is another problem—how to obtain such unanimity among the professions and hospitals as will enable the province to satisfy the dominion that its plan of operation is practicable?

I would like to emphasize that the draft bill is only a chart to guide the provinces along one road to the desired destination. Any reasonable detour from the road to avoid rough spots is deliberately suggested by the bill, itself.

Perhaps I do not need to mention that this bill is not by any means a finished article. It is admitted at once that a good many features of it can be improved. Even since the bill was submitted to your committee, Mr. Chairman, further thought has been given to it by members of the Advisory Committee and some amendments are even now ready for submission to your committee. These amendments will not affect the substance of the bill at all but are mainly for the purpose of improving the working machinery. Doubtless many valuable suggestions along those lines will also be developed out of the discussions which are yet to take place before this Parliamentary Committee.

Now, Mr. Chairman, before I sit down may I just mention one point about the National Fitness Bill to correct an error. It is to draw the attention of this Committee to a slight mistake in one of its clauses. I have been authorized by the Honourable the Minister to bring it to your attention at the first appropriate opportunity. As the National Fitness Bill has already been mentioned several

times in discussion here, and witnesses have appeared on its subject matter, it might be advisable for me to point out this mistake now rather than to wait until the bill, itself, receives detailed attention.

The Minister's original instructions, which were never varied as to this point, were that the Dominion's share of the cost would, subject to the limit imposed by the population measuring-stick, be further limited to one-half of the annual expenditure of the province in carrying out the approved plan. In the transmission of those instructions to the draftsman a change inadvertently crept in with the result that clause 7 of the bill does not properly express the Minister's intention.

It will be necessary, therefore, to amend clause 7 by striking out all words therein following the word "census" where that word last appears and substituting the following:—

"or an amount equal to one-half of the moneys actually expended by such province in carrying out such plan, whichever is the less."

I hope, by introducing this explanation at this particular time, to prevent the formation of conclusions which might follow from the present wording of the clause. I may say that there is also a typographical error in clause 9 in the use of 1941 instead of 1931 in describing a statute.

The CHAIRMAN: Are there any questions?

By Mr. Lalonde:

Q. Has the department received legal opinions from the attorney-general's office in the different provinces with regard either to the provincial or the federal bills?—A. Not to my knowledge, sir.

Q. Do I understand that these regulations made or set up by the provinces will need federal approbation to come into force?—A. They will, sir.

Q. So, I understand that a province cannot set up a regulation itself without the approbation of the federal government?—A. Well, not and get the aid prescribed in the dominion bill.

Q. I am referring to the provincial bill.—A. The province must satisfy the requirements of the dominion bill before it becomes entitled to any aid in carrying out this health insurance plan. Does that answer the point?

Q. Yes. So it is possible that a province could submit to the federal authority a regulation that would not be accepted by the federal authorities?—A. Quite possible.

Q. And in that case refusal can be made by the federal authority to the provincial authority and the bill cannot work in that province?—A. That is right.

By Mr. Maybank:

Q. The provincial bill has to be reasonably close to the one which is a schedule to the Act. Regulations after the approval of the provincial bill would not need dominion approval provided that they are within the four corners of that provincial Act, would they?—A. No, they would not, so long as it is a workable scheme. We contemplate that the dominion would have a knowledge of the regulations that are about to be enacted. I think one can take it for granted that it will take several months or probably a year or more to work out the necessary regulations in any particular province, and the advisory committee has had the thought that during all that period there would be close contact between the dominion and the provinces, so that a province would not need to go ahead and work out a plan without knowing that the dominion would accept it.

By Mr. Howden:

Q. Does it not mean that a province will have to conform to the last schedule of the federal authority before it can obtain assistance?—A. The words of the Act are substantially the same—in substantially the same form as set out in the schedule to the Act; that is the provincial bill.

By Mr. Maybank:

Q. The point I wish to make certain about is this: a province once having passed its law which is acceptable to the dominion would not be in a position of having all its various regulations approved from time to time in case it made changes—approved by the dominion?—A. No.

Q. To bring itself within the four corners of its own Act would be all that would be necessary?—A. That is all. The dominion approves of the main plan, and the details can be worked out by the province concerned.

Q. No province needs to fear that it will have to make continual pilgrimages to Ottawa to get some t's crossed or some i's dotted?—A. No.

By Mr. Shaw:

Q. The witness stated, if I heard him clearly, that he holds no brief for administration by a commission, and he proceeded to show the authority that would be vested by the minister of health in a province in relation to the commission. I wonder if Mr. Gunn could elaborate upon that? Just what authority is this commission to have with or without reference to the provincial minister of health with respect to any legislative work that that commission may undertake? May I clarify the point by saying this: will the commission have authority to make regulations?—A. Subject to the approval of the Lieutenant-Governor in Council.

Hon. Mr. MACKENZIE: Section 56.

Mr. SHAW: I have not the bill before me.

By Mr. Wright:

Q. Would there be any constitutional difficulty involved if the dominion were to insist that the provincial Acts be all-inclusive for all the people within the provinces; that is that there be no salary limitation to the Act?—A. I believe not, sir; the Department of Justice has not raised that point in their study of the bill; they have not raised that difficulty.

Q. It would be constitutional if the Dominion Act included a clause which would insist that the provincial bill be all-inclusive?—A. So far as the dominion's right is concerned, I doubt if the dominion could go that far, but the province can, as you know. The general indication of the Dominion Act is that there is a pious hope that all people shall be included.

Q. It would be unconstitutional for the dominion to insist that that be a condition of the Provincial Act, would it?—A. I would not say that. The dominion may take any stand it likes. It does not need to hand out its money to people who do not comply with the conditions. After all, the dominion is handing out a lot of money to the provinces and it hands out that money only on conditions, and one of those conditions may properly be that all people in the province be included in the scheme.

Mr. HOWDEN: The dominion has left it open.

The WITNESS: That is a matter of policy, of course. There is nothing in the dominion bill which insists—

By Mr. Wright:

Q. My point is, would it be constitutional for the dominion to insist on that clause?—A. I am not prepared to give you a definite answer on that, sir.

Q. Could you get an answer? Could you obtain an answer from the Justice Department?—A. My own personal opinion is that it would be unconstitutional, but the point does not arise here, if I may make so bold as to say so. I would say it is simply a definition of attitude on the part of the government of the day. If the government of the day simply says: We are not going to hand out any dominion money until all the people in the province of Ontario or in any other province are covered by the provincial bill, I think they are quite within their right in adopting that attitude.

By Mr. Shaw:

Q. You have no authority to collect the dues in that province—either the dominion commission or the government— —A. No, none whatever.

By Mr. Johnston:

Q. What would be the legal status there should a province object on the ground that while they may not collect the contributions from individuals yet they are making direct contributions through their dominion taxing, because they are forced to make a contribution whether they accept this national policy or not? Because the dominion is paying the money out of revenue—half of it—and that revenue comes from all the provinces. And so they are forced thereby to make their contribution toward that federal grant for other provinces which are receiving money, and they may decide not to go into the scheme?—A. Is there an obligation on the dominion to make grants to any province for health insurance purposes? Does it not boil down to that? Is there a legal obligation on the part of the Dominion to make grants to any province for health insurance?

Q. No, I would not think there would be; yet if there is one province which does not receive the benefits from this scheme while all the other provinces are receiving them, what position would that province be in?

Hon. Mr. MACKENZIE: Did we not have that exactly in the old age pension matter?

Mr. JOHNSTON: Yes, it is on the same basis as old age pension, but the point is there just the same.

Mr. MAYBANK: It was never contended when Quebec did not undertake old age pensions that the dominion government did not have the right to make grants out of the consolidated revenue, part of which came from Quebec which had not yet undertaken old age pensions itself. No province can impose on the dominion a restriction upon the use of the consolidated revenue.

Mr. SHAW: Mr. Chairman, I have one other question to ask. Let us assume that all the provinces agree to participate in this scheme, they will, therefore, assess the individuals in the provinces according to whatever scale is established; but you will not be in a position to guarantee services, let us say, to those in the more remote areas or in some areas not so remote. Now, is it intended that we shall collect from those people the same amount as we collect from people resident, let us say, in a city where all the services can be made available?

The WITNESS: I think the answer to that is that it is left entirely within the discretion of the province how much to make those people pay who receive not all the benefits and who may not be able to get all the benefits by reason of remoteness.

Mr. SHAW: You would expect a certain amount from the provinces on a per capita basis and let them procure it?

The WITNESS: Yes.

Mr. SHAW: Do I understand it is left with the commission in the province to assess its people as they may see fit?

The WITNESS: Subject to the approval of the Lieutenant Governor in Council.

By Mr. Maybank:

Q. Which Act deals with the subject of migrancy. That matter will undoubtedly give us some trouble. Let us say that Manitoba comes into the scheme and Saskatchewan stays out, then the question of Manitoba collecting money from people living in Manitoba only a short time and then going back to Saskatchewan, would come in—all that migrancy that they run into in the workmen's compensation and the unemployment schemes. Which Act settles

as to the matter of residence?—A. The Provincial Act is the one that contemplates that difficulty, and while there is one clause that deals with it in a general sort of way most of these things are left to regulation, as circumstances may require some reciprocal arrangement between the provinces.

Q. We will probably be in the same position as we were with old age pensions, I suppose, when they tried to get uniformity of regulations?—A. Somewhat the same, I imagine.

By Mr. Wright:

Q. I have not got a copy of the Act before me, but I believe that it states in the Act that if a province complies with certain regulations laid down by the dominion or by the dominion commission that the dominion may pay to the provinces their portion of the cost. Does that “may” mean “shall”?—A. I am inclined to think so, sir.

Q. I would not be satisfied with your “inclined to think so”. Does it mean “shall”?

By Mr. Lalonde:

Q. The question was raised in the house a few years ago.—A. It is difficult for one to say categorically whether it does or not. Sometimes “may” is permissive only, but where there is any duty in connection with it, duty on the part of a person or a corporation or a government, then the usual interpretation is that it is mandatory; that it is to be read as “shall”.

Q. I think in this case it should be “shall”.—A. Perhaps so.

By Mr. Blanchette:

Q. Going back to the question that Mr. Lalonde asked a little while ago, may I ask the witness to date if any province has made any comments or showed any opposition to the non-flexibility of any terms of the draft bill in connection with the intended regulations that the province might wish to put out?—A. Not to my knowledge.

Mr. LALONDE: Consideration of the question of “may” or “shall” was had in the house a few years ago.

The CHAIRMAN: Linguistic questions.

Mr. LALONDE: I think in the Act under discussion at the time Mr. Lapointe stated the word “may” means, in legal phraseology, “shall”.

The CHAIRMAN: That is right.

Mr. JOHNSTON: Then they should put in terms that are understandable.

The CHAIRMAN: It is pretty difficult.

Hon. Mr. MACKENZIE: That is why it is not done.

The CHAIRMAN: It is pretty difficult, Mr. Johnston, to understand legal jargon; at least I find it so. Are there any other questions?

Mr. SHAW: When we are discussing the bill no doubt we will have these gentlemen with us?

The CHAIRMAN: Yes.

Mr. SHAW: Have we heard all the applications?

The CHAIRMAN: The Canadian Legion wishes to be heard. I think perhaps we should hear them next time.

Mr. SHAW: You have not rejected any applications?

The CHAIRMAN: No. We will adjourn now to the call of the chair.

The Committee adjourned to meet again at the call of the chair.

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SESSION 1943

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HOUSE OF COMMONS

SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 26

TUESDAY, JULY 6, 1943

WITNESSES:

Mr. Gilbert Layton, President, Canadian Federation of the Blind;
Mr. J. T. Heggie, M.A., member of the Federal Executive, and Principal
of the School for the Blind, Montreal;
Mrs. Mary Fitzsimmons, President, Hamilton Branch, C.F.B.;
Mr. A. E. Pettapiece, President of Regina Branch, C.F.B.;
Mr. P. A. Brisbois, General Administrator, French Canadian Association
for the Blind;
Mr. J. A. Globensky, President, French Canadian Association for the Blind;
Lt.-Col. W. C. Nicholson, First Vice-President, Canadian Legion, B.E.S.L.;
Captain George Kermack, representing the Imperial Division, B.E.S.L.

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1943



MINUTES OF PROCEEDINGS

TUESDAY, July 6, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Bruce, Coté, Donnelly, Fauteux, Gershaw, Gregory, Hurtubise, Johnston (*Bow River*), MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McGarry, McGregor, Shaw, Slaght and Wood—17.

In attendance were: Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health; Mr. A. D. Watson, Chief Actuary, Department of Insurance; and Mr. W. S. Woods, Associate Deputy Minister, Department of Pensions and National Health.

Mr. Gilbert Layton, President of the Canadian Federation of the Blind, was called. He introduced the delegates of that organization as follows:—

Mrs. Mary Fitzsimmons, President, Hamilton Branch, C.F.B.

Mrs. Alice Cadman, Secretary, Hamilton Branch, C.F.B.

George Medcock, President, Montreal Branch, C.F.B.

Mr. J. T. Heggie, M.A., Member of the Federal Executive and Principal of the School for the Blind, Montreal.

Mr. A. E. Pettapiece, President of the Regina Branch, C.F.B.

Mr. P. A. Brisbois, General Administrator, French Canadian Association for the Blind, Montreal.

Mr. J. A. Globensky, President, French Canadian Association for the Blind.

Mr. Walter Clayton, Director of the Toronto Branch, C.F.B.

Mrs. William Warton, former Secretary, Montreal Branch, C.F.B.

Mr. Layton presented a brief and was examined by the Committee.

The following witnesses were also called and examined:—

Mr. Heggie, Mrs. Fitzsimmons, Mr. Brisbois and Mr. Globensky.

The Chairman thanked the witnesses who then retired.

Lt.-Col. W. C. Nicholson, First Vice-President, Canadian Legion of the British Empire Service League, was called. He introduced the following delegates of the B.E.S.L.:—

Mr. J. C. Herwig, General Secretary;

Mr. Richard Hale, Chief Pensions Officer; and

Capt. George Kermack, representing the Imperial Division.

Col. Nicholson then presented a brief, was examined and retired.

Capt. Kermack was called, presented a brief and was examined. He filed copies of the following documents:—

Imperial Division's presentation before the Special Committee on Soldiers' Affairs in May, 1941;

Memorandum prepared by the Imperial Division on September, 1941, with reference to the number of Imperials resident in Canada who would benefit by their proposals under the War Veterans' Allowance Act.

Summary of the position, prepared by the Imperial Division in March, 1943.

Witness retired.

The Chairman thanked the witnesses and the Committee adjourned at 1.00 o'clock, p.m., to meet again on Thursday, July 8, at 11.00 o'clock, a.m.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

July 6, 1943.

The Special Committee on Social Security met this day at 11 o'clock, a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: This morning we are first to hear representatives of the Canadian Federation of the Blind, and I shall ask Mr. Gilbert Layton to introduce the representatives of the Federation and to present the brief.

GILBERT LAYTON, Federal President, Canadian Federation of the Blind, called.

The WITNESS: Mr. Chairman, Mr. Minister, ladies and gentlemen, we have here to-day representatives from some of the branches of the Canadian Federation of the Blind from different parts of Canada. I shall name them: Mrs. Mary Fitzsimmons, President, Hamilton Branch, C.F.B.; Mrs. Alice Cadman, Secretary, Hamilton Branch, C.F.B.; Mrs. William Warton, former secretary of the Montreal Branch; George Medcock, President, Montreal Branch; J. T. Heggie, M.A. Member of the Federal Executive and Principal of the School for the Blind, Montreal; A. E. Pettapiece, President of the Regina Branch; P. A. Brisbois, General Administrator, French-Canadian Association for the Blind, Montreal; J. A. Globensky, President, French-Canadian Association for the Blind, Montreal; Walter Clayton, Director of the Toronto Branch, C.F.B., and Mr. Johnston.

Mr. Chairman, ladies and gentlemen, permit me first to thank this committee for holding this extra sitting thereby allowing the Canadian Federation of the Blind to make this appearance.

In view of the fact that there are a large number of organizations for and of the blind in this country, it would be well to acquaint this committee with the conditions prevailing amongst the blind in Canada prior to 1926 and as to just what the Canadian Federation of the Blind has done since its founding in that year and what it stands for and means to the sightless of this Dominion to-day. Up to 1908 nothing was being done for the English-speaking blind children in the province of Quebec and there were just three schools throughout Canada, namely: The Nazareth Institute in Montreal; Ontario School at Brantford, and the third in Halifax. In Montreal, a few English-speaking blind children were sent to an institution for the deaf and dumb and there received education and training along with this other severely handicapped class. One does not have to reflect at great length to realize the terrible disadvantages to the sightless of schooling under such circumstances. Sight-saving classes were unheard of, and a large number of babies were born blind each year, whose sight could easily have been saved with simple medical treatment.

Even more outstanding was the fact that there was not a single activity of any kind to help the adult blind, anywhere in Canada. Some few graduates from the schools successfully maintained themselves as music teachers, organists and piano tuners. But the vast majority were allowed to drift after they left school, becoming dependent on friends or relatives or taking to begging on the streets. Quite a large number were even placed in incurable homes. In short Canada lagged far behind other countries in the treatment and care of its blind population.

Since the date of his arrival in this country from England in 1887, the late Philip E. Layton, himself totally blind through an accident, when a boy of thirteen, had been deeply conscious of and seriously concerned about the welfare of the many others handicapped like himself. His own early experiences to get on in this dominion, were typical of the difficulties prevailing at that time. He had hoped to secure a position as a church organist and choir master but found to his bitter disappointment that church committees had no faith in the ability of a blind person to conduct the services. He achieved little more success in his efforts to teach music. However, rather than go back to the old country, he got out his tuning hammer and started from door-to-door tuning pianos. In the course of the next twenty years he achieved considerable success in the business world of Montreal, establishing a well-known firm, merchandising pianos, organs and musical instruments.

During all these years he had never lost sight of the difficulties confronting his fellowmen; it was a subject very dear to his heart and constantly in his mind. He talked to other blind and sighted persons, interesting them and gaining their promise of support at such time as an organization could be started. It was in 1908 that he invited these friends to his home to discuss the whole situation and it was at this gathering that the Montreal Association for the Blind came into being. The organization immediately attracted the sympathetic support of the public of Montreal, with the result that the first workshops for blind men anywhere in Canada were opened in 1908. At first only four men were given employment. For the past thirty-five years the workshops of this association have flourished and expanded giving continuous employment to hundreds of blind men and women. The successful operation of this project was an incentive for the opening of similar workshops in various parts of the country. Mr. Joseph Beaubien, Mayor of Outremont, who was himself blind for a short time but successfully regained his sight through an operation, was a close observer of the results achieved in this first workshop. With the full co-operation and assistance of the Montreal Association for the Blind he organized the French-Canadian Association for the Blind. We are happy that representatives from this Institution are present here to-day and will be heard from a little later on. A school for blind boys and girls was opened in 1912 and for the past 31 years has adequately met the educational needs of the English-speaking blind children of the province of Quebec. A number of pupils from the Prairie Provinces have also received education in this centre. It is believed that the facilities of the school will be employed to much greater advantage, now that compulsory education is in effect in Quebec.

During all these years Mr. Layton was fully aware that it was not possible for workshops or organized charitable institutions to meet all the dire needs of the great mass of the poverty-stricken blind population throughout the country. He had seen from the beginning that the only solution was state aid in the form of pensions. With this object in mind he arranged for the Montreal Association for the Blind to be hosts to delegates from all parts of Canada, at the first National Conference of the Blind in this dominion in 1937. At that gathering the great need of a nationalized organization of the blind was brought home. Such a group had been in operation in Great Britain for many years. It was the national league of the blind and was altogether independent of institutions for the blind. It was decided, therefore, to bring into being the Canadian Federation of the Blind, the organization, ladies and gentlemen, appearing before you to-day. Since that date, branches and affiliated groups have been operating in most of the larger centres of Canada.

From the moment of its inception seventeen years ago the Federation has worked ceaselessly on the pensions question. A delegation from the first meeting, numbering some fifty blind persons, proceeded to Ottawa, and was

received by the Prime Minister, the Right Honourable Mr. Mackenzie King. Year after year the branches of the Federation kept talking and fighting for pensions. They interviewed municipal authorities, waited on provincial governments, and tried to enlist the support of federal members. In 1933 a united memorial representing forty-two organizations for and of the blind was submitted to the dominion government. These efforts were finally crowned with success, when in December 1936 the matter of pensions for the blind was fully discussed at a Dominion-Provincial Conference in Ottawa. It was my privilege to be a delegate from the government of Quebec at that conference and the Hon. Mr. Charles Dunning invited me to address the gathering on the question of pensions for the blind of Canada. Mr. Chairman, I do not believe that I am breaking any confidence when I say that as Mr. Dunning asked the provinces for their opinion, each one wholeheartedly urged the federal government to take early action and undertook that their governments would participate in any scheme that Ottawa might put forward. I am confident that this same spirit and desire to help the unfortunate blind will manifest itself, not only amongst the legislatures of the country, but unanimously with the people of Canada, at any beneficial Act for the blind that it may be possible for parliament to put into effect in the not too distant future.

With the passing of the amendment to the Old Age Pensions in the session of 1937, there was great rejoicing amongst the blind throughout the Dominion's new centre. It was realized that this bill granting a pension of \$20.00 to blind persons at the age of 40 was only a beginning, but it was felt that it was a good beginning. Since that date the Federation has continued to concern itself with the whole problem of the blind in general, and the subject of pensions in particular. The matter has been repeatedly brought forward and discussed by the various branches. At a general meeting of the Federation held in Toronto in the spring of 1940, several months after the death of its president and founder, the weaknesses and inadequacies of the present Act were fully discussed. Representatives from all over Canada were of the opinion that the increased cost of living was working a serious hardship to beneficiaries under the Pension Act. However, it was unanimously agreed, in view of the seriousness of the war situation, to withhold further representations to the government until after the war, or at least until conditions at home and abroad were sufficiently improved to justify Parliament taking action. The far-sighted movement of this Government in endeavouring to prepare to meet post-war conditions, by the setting up of this committee has brought about a change in Federation policy, hence the delegation here to-day.

Just a few more words, ladies and gentlemen, about the Canadian Federation of the Blind, because it is of the greatest importance that this committee should fully recognize the usefulness of and need for such an organization in the direct interests of the blind population of this country. If a dominion commission of provincial commissions for the blind should be set up as a result of the deliberations and findings of this committee and its subsequent recommendations to the house—then it is of prime importance that the blind themselves should be directly represented on all such bodies. Even among the blind, Mr. Chairman, there are sometimes differences between institutions (employers) and workers (labour) and sometimes—yes, frequently—blind labour has proved to be right. Although its primary object was the securing of pensions, the Federation has done invaluable work in other fields of activity. It has served as a strong organized body to fight for and protect the helpless blind, from exploitation at the hands of promoters and others, who strive to use this cause as a means of raising money for their own ends. Improved working conditions in respect of hours and wages for the blind have been secured, and in some cases manufacturing on a small scale has been engaged in, in order to provide

employment for those unable to secure it from existing agencies in certain parts of the country. Not the least important of the federation's operations has been the formation by the branches of social clubs, where the blind gather together regularly to talk over their problems, to hear concerts and lectures and to hold dances and play cards. In short, to bring some degree of sunshine and happiness into the lives of those formerly without any interests outside of their immediate surroundings. All the officers and executives of the Federation are on an entirely honorary basis. The Canadian Federation of the Blind has done much during its seventeen years of existence to improve social, economic and general working conditions among blind Canadians. It intends to continue with untiring energy its efforts in this direction, pressing the claims for recognition of the needs of the mass of blind men and women, boys and girls. The Federation is an organization of the blind, does not seek large government grants or allowances, is representative of no institution, favours no particular province and is not allied to any political party.

The Federation, Mr. Chairman, is taking it for granted that any comprehensive scheme for social security must include special provisions for the blind persons. In the report of Sir William Beveridge it is recommended that the whole welfare of the blind of Great Britain should be the responsibility of a proposed ministry of social security, in conjunction with local authorities and voluntary agencies.

The report makes it abundantly clear that blind people should not be regarded as incapacitated but rather as handicapped and deserving of assistance. In other words, in allocating cash payments to blind persons they should be considered as compensation for blindness and not pensions.

The Blind Persons' Act of 1920 of Great Britain placed the responsibility upon local authorities to care for the blind in their respective areas, and consequently the sightless of that country have been assured of a certain degree of social security and protection. The chief objection to that system is the lack of uniformity in the administration of the Act in the various municipalities.

In Australia a pension for the blind is paid at the age of sixteen, while in New Zealand the age is fixed at twenty. The responsibility for the blind in the United States is assumed by the respective states. The situation there differs widely in various parts of the country. Some states have some form of pension, some subsidize employment, while a few do very little. Congress is presently making a study of the whole problem and it is anticipated that some constructive action will be taken shortly. Prior to the war a variety of systems were in effect to aid the blind in the countries of Europe. It is more than likely that what Canada does for its blind will be closely watched by other nations.

The amount of the pension here is totally inadequate. Under present conditions it is most difficult to arrive at a figure that will meet every need and every situation. Varying amounts have been suggested by our branches and individuals in different parts of the country, ranging from \$30 to \$60 dollars per month. This organization, Mr. Chairman, believes that the amount must be sufficient to provide the necessities and a few of the comforts of life. It should also be large enough to pay for the cost of a guide. There are undoubtedly quite a number of blind men and women who might successfully engage in certain businesses or professions, but the cost of guidance and transportation in their cases makes it difficult for them to compete with sighted people engaging in the same practice. Even a seeing-eye dog presents a problem of maintenance that is most serious to a blind person whose pension is only \$20 monthly. In fixing the amount of pension or compensation it should be made sufficiently flexible to meet the ever changing cost of living. That is an outstanding weakness of the present Act. The government has recognized this situation with respect to great war veteran pensioners; but, one or two provinces to the contrary, most blind pensioners still have to get along on their meagre \$20 per month.

The setting of the age of forty at which a blind person is eligible to receive a pension is discriminatory. It was probably arrived at because of representation made by organizations for and of the blind prior to 1937. It must be admitted now that all these groups lacked the courage to press for too many concessions—fearing that the whole matter might again be put off due to the cost. The timidity had probably been acquired through repeated disappointments—when the matter was discussed year after year in the house with members of all parties supporting the private bill—with no objections—and yet the question was always shelved for one reason or another. It is a matter of no great wonder that the blind after ten years continuous struggle were prepared to accept any amount and any age—just so long as something was put into effect. Sir William Beveridge points out “The plan of treating blind persons as if they were prematurely aged is not in accord with realities. Blind persons, though they may need some allowance to compensate them for their infirmity, should not get it in a form which assumes that they are past work and discourages earning. Nor is there any virtue in believing the age of 40 as that at which blind persons are presumed to become the equivalent of sighted persons of 70”. The Federation has followed with interest many of the representations made to this committee. One that attracted our attention was that of F. S. Burke, M.D., of the Department of Pensions and National Health, who in one of his tables shows a breakdown of the various age groups in Canada. The fact that only 2.648 per cent of the blind of this country are under 16 years of age is most significant. Surely, Mr. Chairman, when the question of age is under consideration it might be just as well to recommend that compensation be paid to all blind persons irrespective of age. The small number who would be eligible in the lower age brackets would present only a minor financial problem.

The present law does not encourage a pensioner to seek employment. This is probably one of the most serious weaknesses of the plan. If a blind person does secure a job he is immediately faced with the curtailment or cancellation of his pension and secondly, if his job proves to be only temporary there is altogether too much delay in reinstating him again on the pension rolls. There are a great number of men and women above the ages of 18 who can be gainfully employed. In many cases their handicap will not permit them to earn sufficient wages to adequately or comfortably support themselves. Those in this group should definitely be given some direct financial aid or augmentation to supplement their earnings. This compensation should be on a broad and generous plan designed to encourage full or part time employment. Just what employment is to a blind person cannot be altogether computed in dollars and cents, but the provision and support of such employment, by a government, is most certainly one of the finest investments that can be made. A job—a place to go daily, the feeling of being able, though deprived of sight, to earn a living, to be free of dependance on relations, friends and charity; the wherewithal to be married, raise a family, live a nearly normal life—this job has no limits to its compensative values.

Some workshops for the blind have systems of augmentations for their workers over and above their actual earnings, but they should be relieved of this burden. Funds for such compensation are generally procured from charitable sources. If the particular institution fails to secure sufficient contributions, the augmentation may have to be cut or cancelled. It would mean a tremendous improvement to the morale and confidence of sightless employees if the augmentation came directly from the government as their right and particular privilege, it would also serve to ease the burden on institutions, releasing funds for research and other purposes.

There is another point, ladies and gentlemen, on the subject of employment of blind persons in sighted industries. Under the peculiar conditions that

obtained during the late twenties and again at the present time due to the shortage of labour, many blind and partially blind men and women are absorbed into industry where they become quite efficient on certain machines and in certain capacities. But it is folly to believe or to claim that they can in many cases do the job just as well as an unhandicapped person. Even though this be true there are many to-day who are playing a valuable and productive part in the war effort. When conditions get back to normal we shall be faced with the same situation as came into effect in 1930. Those who cannot produce on an equal and competitive basis with sighted workers will be let out and faced with unemployment. It would serve a most useful purpose if this committee could find some way of making it an obligation for large concerns to absorb a certain percentage of blind workers, in fact, all handicapped classes, into their industries. Certainly, if a sightless worker were in receipt of a government compensation the burden on the employer would probably be nil as the comparative value of blind and sighted workers would be levelled by this means. If this is not done then local institutions and workshops will face a serious problem to find work for the many who are presently self-supporting.

The above phase of the situation is one that requires immediate consideration and early action by parliament. The Federation respectfully urges early action on this point by this committee.

It has been stated above that blind persons should be encouraged to seek employment, however, under the present Act a pensioner who is unmarried may have only \$200.00 additional earnings or income. If he secures a position and earns \$100.00 and reports it to his provincial commission, his pension is immediately cut. The Federation has noted with interest the recommendation submitted by the Canadian National Institute for the Blind on June 18th, for a sliding scale or graduated pension rate. The Federation believes that this plan has merit, however, it feels that the scale should be much more generous than that suggested. The Federation is of the opinion that before any deductions are made the permissible earnings should be approximately doubled. The Federation believes a single man should be allowed to have \$500.00 income in addition to his pension and a married man \$1,000.00. From that point on a 50 per cent graduated deduction rate from earnings might be fair, although the Federation is of the opinion that a scale based on a rate of 25 per cent deduction on additional earnings would prove a tremendous incentive for blind persons to try to become completely independent in spite of their great handicap.

The Federation has noted with interest the report of the Dominion Council of Health to this committee. It congratulates the council upon its able and thorough presentation, it is in full agreement with the six points specified in that report, pertaining to the blind, subject to the comments and limitations in this brief. Just one word in support of prevention of blindness and sight-saving. Every dominion and provincial health body should be given the necessary financial allocations to fully meet the situations as outlined by the Dominion Council of Health. It should be readily apparent, ladies and gentlemen, that aside from the humane side of the question the economic results and gains achieved by preventing blindness will offset expenditures many times over. It is interesting to note in the reports of state organizations and commissions to the south that the numbers of those receiving pensions are steadily decreasing. In a pre-war report the Missouri State Commission for the Blind shows a reduction from 4,346 to 3,869 in a period of three years. If such a ratio of decrease could be achieved in this country, it would not be very long before the numbers of blind persons receiving compensation would be almost negligible, and the financial burden equally so.

The "means test" with respect to the administration of the Act is far too severe. It should not be necessary for a blind person to have spent practically his last dollar, sold his last piece of property, or realized on his last tangible asset before he can be considered as a full beneficiary under any pension plan.

Under the present Act the pension of a blind person marrying another blind person is reduced by half. It is certainly open to question as to whether two blind persons otherwise healthy and normal, should be penalized if they marry. This is an unfair and discriminatory feature and should be eliminated from any new Act.

The present residence restrictions also work considerable hardship to blind pensioners. Any new plan should eliminate these restrictions, or at least make them more elastic.

The Federation, Mr. Chairman, has endeavoured to bring to the members of this committee the needs of the blind civilians of Canada. While these representations may not be backed by the factual and statistical data that a committee, such as this, is accustomed to receive, they are based upon observations and personal intimate contacts with blind men and women, boys and girls in every part of the country. These observations and experiences enable the Federation to make the following recommendations which it believes to be an absolute minimum to be embodied in any new legislation that the parliament of Canada may see fit to bring forward.

1. A compensation of \$30.00 monthly.

I would like to add \$30.00 monthly for single persons; additional for married persons.

2. Cost of living bonus.
3. Payable as a compensation for blindness irrespective of age.
4. Single persons should be allowed other income up to \$400.00. Married, \$1,000.00.
5. Applicant should be allowed to have cash in the bank or securities up to \$500.00.
6. Applicant should be allowed to own property up to the value of \$3,500.00.
7. Cash and property should be exempt from assignment to the government after the death of the owner.
8. Property value should be calculated on the lower of the market or assessed value.
9. Residence eligibility should be five years in Canada, irrespective of change in provincial domicile.
10. No deductions for blind persons marrying each other.
11. Free medical and dental care and hospitalization from birth.
12. There should be a special blind persons act.

Mr. Chairman, the Canadian Federation of the Blind again thanks you for this opportunity of appearing before the Special Committee on Social Security. There are, as you have been informed, branch representatives of this organization from several points in Canada. Some of them, I believe would like to add a few words to this brief.

The CHAIRMAN: Thank you, Mr. Layton. Now, are there any questions?

By Mr. Wood:

Q: Mr. Chairman, did I understand that only 2.6 per cent of the blind people are under the age of 16 years?—A. Yes. That is according to the figures received by you on June 18 and submitted by Dr. Burke.

Q. I have in mind particularly the school for the blind in my locality of Brantford, and I notice that the students there are mostly under 16 years of age. Is there any endeavour on the part of the Federation to encourage students to go to those schools where they are dealing with complete impairment of eyesight;

has that been encouraged?—A. I cannot say that the Federation has encouraged or discouraged them because that is not the activity of the Federation; they have nothing to do with the direct education. They have no funds for the sending of pupils to these schools. Definitely, in their various localities, if they run into a blind child they try to prevail upon the local authorities to find the wherewithal to send that child to some form of school.

Q. They do not offer any recommendation with regard to the training they get in those particular schools?—A. Do you mean that our recommendations do not deal with that matter?

Q. Yes; the type of training they should get in those schools? That is to say, whether elementary academic training is more useful to a blind person than vocational training. I would like to have your opinion on that matter?—A. I will ask Mr. Heggie to answer that question.

Mr. HEGGIE: It is very desirable that technical schools for the blind should be established. In the report I made to the Quebec government not long ago I emphasized that as most blind people have to earn their living by the use of their hands, greater effort should be made to establish technical schools giving the fullest and most complete training so that the blind people will be able to earn their living by their hands.

Mr. WOOD: I am glad to hear that. I feel from my association with the training centre at Brantford that what Mr. Heggie has pointed out has borne out my particular viewpoint, that the technical and vocational part of the education has been somewhat recommended.

The WITNESS: I am sure you are right; that has been our experience.

The CHAIRMAN: Are there any other questions for Mr. Layton, or would any others of the delegation wish to add a word?

The WITNESS: I should like to ask Mr. Pettapiece, who has come down here from Regina, to say a word.

Mr. PETTAPIECE: Mr. Chairman and members of the committee, with regard to the question which Mr. Wood asked regarding education I may say that in Saskatchewan compulsory education of blind children is imposed by the government, and they are sent down here to the Brantford school for the blind. An average of twenty each year come from Saskatchewan. That would correspond, I think, fairly well with the percentage referred to by Mr. Layton as under the age of 16. In the province of Saskatchewan there are approximately 900 blind people. Some years ago the Regina branch of the Federation approached the Saskatchewan government with regard to assistance and asked for a regulation allowing a boy or a girl who had passed the eighth grade examinations in the school for the blind to continue their education in the sighted schools and recently in the universities, and we have encouraged our blind people in Saskatchewan to take advantage of that regulation, and several have. Up to the present time the Federation has been assisting a blind girl to take a dictaphone stenographic course and we hope that she will be a success. That is an example of what we consider should be done for our sightless boys and girls who are ambitious and wish to equip themselves for office work. There are a great many problems in the west which I think probably do not affect the blind people in the east so much. One has to do with industry. We have not got the large centres in the prairie provinces which have industries in which the blind can work that you have in the east; and it is certain that not so many are employed. In Winnipeg I believe there are forty or fifty blind persons employed in the workshop; outside of that there is very little employment for the blind except in concession stands such as cigar and news-stands and small confectioneries. These are limited in districts where there are not many large centres. In Saskatchewan there are only six or eight

of those concession stands in operation. We have approached our government out there in connection with employable and ambitious young blind persons and have asked that they should be encouraged to go into some industry for themselves; even out in the country—to go into something that could be managed successfully even by sightless persons, possibly with a little help, and if financial assistance were necessary to advance assistance to them; because we consider that anything of that kind would be an asset since it would gradually take the blind people out of the liability to the community class. These are things that we are encouraging in the west. We have approached our government quite frequently regarding state hospital and medical assistance—free hospital and medical assistance for blind persons. In Saskatchewan the State Hospital and Medical League are working on a plan which would include everybody, sightless as well as sighted, and we are fully behind that because it fills the bill of what we have been trying to get for our sightless people. The publicity committee of our branch out there is the publicity committee of this league, and that is one thing that we are 100 per cent behind; we are fully in accord with the scheme because we think it will benefit our sightless people even more than it will benefit sighted people. If plans of that kind were put into operation, medical services and dental services and treatments of eyes would be available to everybody all through the country. That has been borne out where the practice has been carried on where services are available, to the extent that a regulation of the Department of Health in Saskatchewan makes it compulsory that eyedrops be used at birth, and this has proved to be a great factor in reducing the percentage of blindness where that regulation can be carried out. However, there are many hundreds of births which are unattended by either doctors or nurses, and in those cases this plan cannot be carried out. We feel that a plan such as we are supporting out there would eliminate the expense of educating many blind persons who are sent from the prairie provinces to schools for the blind.

There is another thing we have been trying to impress on our provincial government. There are many features in connection with blind welfare that we think could be changed and which would be of benefit not only to our sightless people but it would relieve the financial strain also which is connected with blind welfare work under the system that the government is using at present. We consider, and we have made these representations to our government, that blind welfare work and services of sight should be directed by a department of the government and not be left to any private organization. We think it is unjust, it is unfair to the blind, to have their sight entrusted to any private organization. We believe that the government should be responsible wholly for that. Blindness is a national calamity and is, therefore, a national responsibility; and we think, as I say, that it is unfair to the sightless people to have the care of their eyes entrusted to any private organization.

These are some of the recommendations that we have presented to our Saskatchewan government which have not been touched on in the brief which Mr. Layton has presented to you. We are fully in accord in the west with the recommendations that are made here by our president, and we hope that this committee will take into consideration the condition existing in the western part of Canada as well as that existing in the eastern part.

The CHAIRMAN: I would like to point out that under the health insurance plan submitted for study and consideration in this committee blind persons will benefit and those benefits will include preventive treatment.

By Mr. Cote:

Q. Mr. Chairman, I missed a part of the interesting presentation which has been made this morning and it is possible that what I have in mind has been

covered by the brief. I should like to know what influence, if any, the development of our industries due to the war may have on the employment of the blind either as skilled or semi-skilled workers? Have the blind benefited at all by virtue of employment in our war industries?—A. Mr. Chairman, I believe that point was covered partially in our brief, and I may say very definitely that it has influenced employment. Blind people have definitely been able to gain employment easily. In our own organization, in the Montreal Association of the Blind workshops—and this applies particularly to partially blind people—we have lost several young men whom we have treated and who have received the same benefits as blind people. The partially blind have graduated from the school and have gone into the workshops and have constantly realized that they have plenty of sight and have gone out to work, and instead of making \$15 a week or \$18 a week they have been able to make \$30 or \$35 a week. It is questionable whether they will have sufficient sight to retain those positions after the war.

Q. I have in mind the case of two young ladies in my riding who have not been able to get employment and they have been looking for employment for the last couple of months?—A. In Montreal we receive calls from large industries, war-time industries, asking us if we can provide groups of six or eight blind persons to fill certain positions. Frankly, among the English speaking in Montreal we can find practically no more employable blind than are presently occupied. There might be a dozen in the whole of the city who are able to work but who for their own good reasons do not wish to work.

Now, Sir William Beveridge points out that blindness is a handicap not only in earning but also in occupations such as that of housewife. We have with us to-day a housewife and the mother of seven or eight children who is the president of Hamilton branch. I refer to Mrs. Fitzsimmons, and I should like Mrs. Fitzsimmons to say a word.

Mrs. FITZSIMMONS: Mr. Chairman, ladies and gentlemen, there is a point I would like to stress here to-day. When a housewife or a mother goes suddenly blind naturally the doctors want to know the cause and she is rushed to a hospital and bills are incurred usually as the result. Somebody has to be paid to go in and look after the children. The husband is an ordinary working man and he is faced with these bills. If the mother comes home and is incurable she has not only her loss of sight to worry about but she has these bills to worry about also; my point is that a housewife and mother should be recompensed for the loss of her sight so as to help her carry on. I believe that any sightless housewife or mother, after she gets adjusted, will do her housework and raise her family as well as any sighted person, and I believe, as Mr. Layton has said here to-day, that instead of getting a pension they should be recompensed for the loss of their sight. That is my point of view.

The CHAIRMAN: Thank you, Mrs. Fitzsimmons.

The WITNESS: Mr. Chairman, we have with us to-day representatives of the largest French-Canadian organization for the blind in Canada. In fact, it is the only active one operating a workshop. Both Mr. Brisbois, the general administrator, and Mr. Globensky, the president of the French Canadian Association for the Blind of Montreal, are here, and I will ask Mr. Brisbois to say a word on behalf of the French-Canadian blind.

Mr. BRISBOIS: Mr. Chairman, Hon. Mr. Mackenzie, ladies and gentlemen, the French Canadian Association for the Blind wish to thank Mr. Layton of the Montreal Association for the Blind of the Canadian Federation of the Blind for this opportunity to be members of this important delegation. Our activities are principally providing employment for blind workers through the operations of our shops. Our aims are to keep our members busy so as to provide them with

earning power to maintain themselves. The number of employees at the present time is over 100, and they produce more than 1,500 brooms a day besides producing numerous other articles which can be disposed of. We consider this form of occupation through sheltered workshops as the best means of providing conditions of employment for large numbers of blind men and women; and we believe that the blind people should be encouraged to earn as much as possible over and above any compensation that the government may provide.

Now, it is my privilege to introduce Mr. J. A. Globensky, the President of the French Canadian Association, who will say a few words to you in French.

(French)

Mr. GLOBENSKY: Ladies and Gentlemen,—As President of the French Canadian Association for the Blind (*l'Association canadienne-française des Aveugles*), it gives me pleasure to thank Mr. Layton for the opportunity he has afforded us of joining in this delegation.

It is just that you should hear from French Quebec, seeing that we form the most important association in point of numbers, etc., and the most important in the country from the standpoint of industry.

Mr. J. A. Globensky stresses the necessity for a blind person to receive satisfactory wages while benefitting by a compensation or a portion of a compensation. The minimum wage of a blind person should be set at \$660 for a single man and at a higher figure for a married man.

This amount of \$660 represents the minimum wage a single man can receive without coming within the provisions of the income tax or suffering a reduction in his compensation.

Assured as we are that the Government is taking into serious consideration the petition of the Canadian Federation of the Blind presented by Mr. Layton and the observations made by our administrator, Mr. P. A. Brisebois, we thank the Committee on Social Security for their kind attention.

The CHAIRMAN: On behalf of the committee, Mr. Layton, I wish to thank you and your associates for coming here to-day and presenting your interesting brief.

Mr. LAYTON: We are thankful to your committee for the privilege of appearing here.

The CHAIRMAN: We are now to have the honour of hearing from the Canadian Legion of the British Empire Service League, and I shall ask Colonel Nicholson to present the brief.

LT.-COL. W. C. NICHOLSON, First Vice-President, The Canadian Legion of the British Empire Service League, called.

The WITNESS: Mr. Chairman, Mr. Minister, and honourable members, on behalf of the Canadian Legion I wish to thank you for the opportunity you have given us to present this short brief on social security. It is presented, naturally, from the point of view and from the angle of the returned man. I may say that I have with me to-day Mr. J. C. G. Herwig, General Secretary; Richard Hale, Chief Pensions Officer; and Captain George Kermack, representing the Imperial Division.

The Legion desires at the outset to express the view that the best form of social security any country can establish for its people is full employment for all those able and willing to work, at wages, even in the lowest brackets, sufficient to provide a standard of living well above the subsistence level. In addition, adequate provision must be made to maintain or to restore the health and morale of those who become temporarily unemployed because of ill health or because, through no fault of their own, they cannot be continuously employed. Provision must also be made for those who become unemployable because of incapacity or old age.

In this brief the Canadian Legion will mainly deal with the social security problems of ex-service men and those which the men of the fighting forces now on active service will face upon their return to civil life. We can take it for granted that they will wish and expect to return to remunerative employment of some kind at the earliest possible moment after their discharge. However, this aspect of their problem is not the concern of this committee, which has been requested to report on a national plan for social insurance which will suit Canadian conditions and yet furnish social security for the whole of Canada.

The Canadian Legion is assuming that this committee will eventually bring in recommendations for a plan to cover social security needs of all Canadians, including in all probability such measures as health insurance, unemployment insurance, insurance provision for old age, retirement and children's allowances, and possibly marriage, maternity and funeral benefits and workmen's compensation. We realize it is possible, and may be desirable because of our peculiar Canadian conditions, to establish social security measures gradually rather than to first draw up a plan complete in every detail, and introduce it at some future time. It may also be desirable to build on existing measures. Many discussions with provincial governments will be necessary and deliberations will extend to other sessions of parliament before a complete system of social security for Canada is established.

Federal-Provincial Relations

The Legion, however, insists that immediate action must be taken to deal with some fundamental problems of social security which cannot wait a too lengthy preparation if measures to deal with the post-discharge period are to meet the national need. For example, the problems involved in bringing about harmony between the federal, provincial and municipal elements, necessary to administration of a national plan, should now be receiving consideration. In this connection, we bring to the attention of this committee the following expression of opinion presented by the Legion to the Royal Commission on Dominion-Provincial Relations, in May 1938, regarding our social system:—

It should be recognized that, since the passing of the British North America Act, the whole social system has undergone almost revolutionary change for which our present rigid constitution is ill adapted. Some elasticity must be provided and consideration given to the fact that the process of change is by no means complete and that a strong central government, which we contemplate, must be in a position to deal with these processes. If we are a nation, then all our nationals are entitled to equal treatment. This can only be ensured by national action; and you cannot have a united and happy people if rich and prosperous areas are accorded privileges which are denied less fortunate areas because the local government is incapable of meeting the need. At present the Canadian economy is one, and all the important tools of economic policy are under federal jurisdiction, e.g., the tariff and external relations, trade agreements, internal peace, banking, railways, etc., and yet all the social legislation made necessary as a consequence of economic development is under provincial jurisdiction and many of the Provinces have collapsed under the burden. In other words, the central authority determines, as far as possible, the economic trend of our national life but the resulting domestic problems are the responsibility of another authority. This is unsound. Certainly men returning from the war will have a right to expect that the problems of jurisdiction and administration in relation to social security measures will have been solved—at least in so far as they affect this particular phase of post-war planning. It should be possible to secure that harmony of aim and

practice that will produce decent living conditions, especially for one who is or becomes incapacitated or unemployable, whether his condition is due to war service or not.

Social Security After the Last War

Following the conclusion of the war of 1914-18 the federal government assumed full responsibility for the rehabilitation of men discharged from the armed forces. Hospitalization and vocational training, with pay and allowances, were provided for the disabled, and a placement service and land settlement for the fit. Cash assistance through a government subsidy to the Canadian patriotic fund was also made available to all bona fide unemployed veterans, disabled or otherwise.

The Department of Soldiers' Civil Re-establishment set the following relief rates for pensioners or those entitled to benefits from the department:—

	Per month
Single	\$ 50 00
Man and wife.....	75 00
Man and wife, 1 child	87 00
Man and wife, 2 children.....	97 00
Maximum	100 00

The federal government, therefore, by direct action or by subsidy provided all the elements of social security to all veterans for a limited period only. Later, the benefits to fit veterans were reduced or discontinued and the cash assistance granted to the unemployed veterans was confined to pensioners only. The rates were drastically reduced in July, 1935, to a maximum, including pension as follows:—

	Per month
Single	\$ 18 75
Man and wife	30 00
Man and wife, 1 child.....	34 50
Man and wife, 2 children	39 50
For each additional dependent.....	3 00

In 1930, however, with the introduction of the War Veterans' Allowance Act and new provisions in the Treatment Regulations, responsibility was again assumed for a limited group, namely, those veterans who had seen service in an actual theatre of war and were "burnt-out" or were indigent and in need of remedial treatment.

These "Social Security" measures for veterans, therefore, divided returned men of the last war into two categories; those who are entitled to receive consideration from the federal government and those who must take their place with other citizens and become the responsibility of a province or municipality. If federal government responsibility is again limited in a similar manner, many thousands of veterans of this war will have to look to whatever social security measures now exist or may develop from the deliberations of this committee.

Social Security in Terms of Necessities of Life

The average man thinks of social security in terms of a cash payment, whether earned or not. He wants to know what necessities of life, including care while sick, that cash will buy at prevailing prices. This is precisely what the discharged soldier of the present war will be thinking about after pay and allowances cease and until he is settled in some suitable civilian occupation paying a good salary or wage. Any scheme which fails to provide the necessities of life for the individual or family unit in sufficient measure to maintain health and morale will fail to provide social security.

New rates of subsistence for ex-service men have recently been established by the government for vocational training, out-of-work benefit and while undergoing hospitalization and securing education.

In this connection I will direct your attention to the appendix which appears at the end of our submission in which the rates are fully set forth covering payments to single men and those with various dependents.

Both the measures and the rates are a great improvement on what was previously in force. The government has also recognized the need for additional allowances for children. These, however, will be in effect for a limited period only and should re-establishment not have occurred within that period, those affected will have no means of livelihood except municipal relief unless a definite scheme of social security is adopted. It is a bold man who would prophesy that unemployment will not exist in considerable measure in different industries and different localities immediately after the termination of this war. Our plans must be adequate to take care of such conditions, be the period of short or long duration. This is a pressing problem which must be considered immediately no matter what long-range plans may be adopted.

Unemployment Insurance Act Rates Inadequate

The out-of-work benefit provided under the schedule referred to is definitely linked with the schedule of benefit rates of the Unemployment Insurance Act. This Act, however, contains no provision for children, the maximum payable being \$12.24 per week for a single person, and \$14.40 per week for a person with dependent.

The temporary measures to fit men for self-support and to relieve post-discharge unemployment are more generous as to rates of subsistence in that they include provision for children, and in our opinion they do establish a basis for determining an adequate social security rate for Canada. Certain it is that the rates in the unemployment schedule alone will be inadequate without some provision for children's allowances, should there be any lengthy periods of unemployment.

Sub-Standard Wages must be Supplemented by Children's Allowances

The Legion would like to record its view that employment does not provide social security unless the wage is adequate. Therefore, we think that some relationship must exist between a social security rate and a minimum wage, and that both should be definitely linked with the cost-of-living index. Low wage rates which do not provide adequately for a family must be supplemented by children's allowances if we are going to abolish abject poverty. There is now a definite feeling that if an industry or business cannot pay a living wage, then the state has some responsibility in the matter, as far as the children are concerned at least. Furthermore, if such conditions exist over a long period the question might properly be asked whether such business or industry is contributing anything at all to the country's benefit.

War Veterans' Allowance Act

Of all measures benefiting returned men the War Veterans' Allowance Act—providing for unemployability and for premature old age—has been the most generally applauded. It provides a monthly income to any veteran who can qualify at the age of 60, or who has some physical or mental defect making it impossible for him to earn a living or who is totally incapacitated. The rate payable to a single man is \$20 a month, and to a married man \$40 a month. These rates have recently been supplemented by an extra \$5 for a single man and \$10 for a married man, as recognition of an increase in the cost of living. An interesting feature about this legislation is that the recipient is permitted casual

earnings, which will not affect the rates payable unless the total income exceeds a statutory limit. It is possible in some cases for a recipient to receive a total income, including the allowance, of \$850 per annum if married and \$480 per annum if single.

It is to the basic rates of this measure that the Legion has taken exception. They are totally inadequate for the man who has no other source of income. It was found that many single men and men with families were endeavouring to exist on the basic rate without additional income of any kind. It is for this reason that supplementation was authorized by the government in 1942 to provide \$25 per month to a single man without other income, and \$50 per month to a married man without other income. In the Legion's view the amounts provided are still inadequate for proper maintenance under present conditions.

In explaining the cost-of-living weighting index system employed by the Labour department (see page 534, *Labour Gazette*, April 1943) a percentage distribution of the annual living expenditures of an average Canadian wage-earner family is used, covering such items as food, shelter, fuel, clothing, etc. The following table indicates this average percentage of outlay as applied to the basic payment per month of War Veterans' Allowance (married and single) also with supplementation:—

Item	Per Cent	Basic Rate per Month	
		M.	S.
Food	31·3	\$12 52	\$6 26
Shelter	19·1	7 64	3 82
Fuel	6·4	2 56	1 28
Clothing	11·7	4 68	2 34
Home Requirements	8·9	3 56	1 78
Miscellaneous	22·6	9 04	4 52
	100·	\$40 00	\$20 00

Item	Per Cent	Basic Rate per Month with Supplementation	
		M.	S.
Food	31·3	\$15 65	\$7 82
Shelter	19·1	9 55	4 83
Fuel	6·4	3 20	1 60
Clothing	11·7	5 85	2 93
Home Requirements	8·9	4 45	2 22
Miscellaneous	22·6	11 30	5 60
	100·	\$50 00	\$25 00

Miscellaneous items are Health 4·3 per cent; Personal Care 1·7 per cent; Transportation 5·6 per cent; Recreation 5·8 per cent; Life Insurance 5·2 per cent.

It is clear from these figures that the recipient of War Veterans' Allowance cannot spend his money according to the habits of the average Canadian. A large proportion of the money allotted to miscellaneous items would have to be applied to food, shelter, fuel and clothing. At present cost-of-living level, the Legion submits that the present rates of allowances, even with supplementation, are insufficient for adequate maintenance.

In dealing with this question at the Winnipeg convention of the Legion, in May, 1942, a resolution was adopted urging that the basic rates of war veterans' allowance be raised to \$30 per month, single, and \$60 per month, married. Since then, as already stated, the government has struck a higher rate of allowances for post-war maintenance of discharged men. That is the reference to the appendix which sets forth the higher rates. The Legion, therefore, feels it can properly ask that early steps be taken to establish a more adequate rate for recipients of war veterans' allowance who have no other source of income.

Provision for Children

It will be noted that no provision is made for children under the War Veterans' Allowance Act, yet many recipients of war veterans' allowance have children to maintain. In provinces where mothers' allowances are in effect something additional is available, but the two combined are still inadequate to provide bare necessities. A case in point will illustrate the situation. There is a family of five children in London, Ontario. The father is in a sanitarium suffering from tuberculosis. Being incapacitated, he receives married rates of war veterans' allowance. His wife is entitled to mothers' allowance for the care of the children. If this family were receiving maximum payments from both sources, the income available would be \$105. However, the federal practice is to apportion \$15 a month of the war veterans' allowance to the provincial institution for the man's maintenance, leaving \$25 for the wife and children. The mothers' allowance, however, supplements this by another \$20, making a total of \$45 per month to maintain herself and her five children. This, we submit, is insufficient to maintain this family in good health. The result is that all the children are now suffering from tuberculosis and one daughter has joined her father in the sanitarium. The wife is attempting to provide for her children at the rate of \$90 per person per year which results in deficiencies in all nutritive requirements. According to a survey conducted during 1937-38 and published by the Bureau of Statistics, it was found that families with annual incomes under \$199 per person per year—that survey was conducted in 1937-38—were deficient in all nutritive requirements when compared with the Canadian dietary standard which is being so much advertised by the government to-day. These deficiencies range from 8 per cent deficiency in calories to 36 per cent in calcium, which is to be found in milk, and milk purchases amount to 49 per cent of standard requirements. This survey found that only at the \$400 to \$499 per year income level per person was there satisfactory nutrition. While malnutrition may not be entirely due to low incomes, the findings of this survey are most disturbing.

It is obvious, therefore, that the allowances available for war veterans' allowance recipients with dependent children are totally inadequate to maintain health and morale.

The Legion, therefore, strongly urges the introduction of a uniform system of children's allowances throughout Canada which, if paid in conjunction with war veterans' allowance, should remain adequate for the purposes for which they are granted.

The incapacitated single man is little better off. It is practically impossible in urban centres to provide for the necessities of life on \$25 per month. Such an individual must either find relatives or friends with whom he can live, or he must enter an institution of some kind. Failing this, he lives under the most depressed conditions.

Extension of War Veterans' Allowance To All Canadian Ex-Service Men

The benefits of war veterans' allowance are confined to only those who served in an actual theatre of war. The Legion, however, has gone on record as favouring the inclusion of all ex-service men who served outside of Canada. It

also favours the extension of war veterans' allowance to ex-service men of the Imperial Forces who were resident in Canada on September 1, 1930, and have continued to reside in Canada.

In respect to Canadian ex-service men who at present cannot qualify, it is submitted that if social security measures are to be extended to all citizens then men who served beyond the shores of Canada and in Canada, although not in what has been defined as a theatre of actual war for the purposes of this Act, should not be treated differently solely on that account. It can be argued that many men who served in Belgium and France or other theatres of war saw no more actual combat than the man who was obliged to remain in England. Furthermore, many men were kept in England because of their age, and such men merit all the consideration that can be given them because they undertook the hazards of military training and duties so late in life.

The Veterans' Guard

Another class which must be considered are those veterans of the last war who have re-enlisted for service in this war in the veterans' guard and other units, some of whom may have served in England only, but because of their second period of service will be too old by the time they are discharged for re-establishment into civilian occupations. These men should not be denied the benefits of the War Veterans' Allowance Act because they were unable to serve in an actual theatre of war.

Extension of War Veterans' Allowance To Imperial Ex-Service Men

The case of the Imperial veteran is of a different character. From time to time, resolutions have been passed by the dominion conventions of the Legion in favour of the extension of war veterans' allowance to Imperial ex-service men after a reasonable period of residence in Canada. At the Legion convention held in Winnipeg in 1942 the following resolution was adopted:—

That we urge upon the dominion government the expediency and necessity of making prompt adequate provision for ex-service men of the Imperial forces by the extension of war veterans' allowance under the same conditions as to Canadian veterans, other than on the question of pre-war domicile, providing such Imperial ex-service men were resident in Canada on September 1, 1930, and have since resided in Canada.

From the foregoing it will be realized that The Canadian Legion feels strongly that Imperial ex-service men with a long period of residence should be given the same treatment as Canadian ex-service men in their old age. The War Veterans' Allowance Act, although confined to ex-service men, is social security legislation providing, as it does, a subsistence allowance at an earlier age than old age pension. It is on this basis that there is a strong case for equal treatment if Imperial veterans, qualified by a reasonable period of residence in Canada, with their Canadian comrades. These men fought side by side with Canadians. They became good citizens of Canada, contributing their share to the public weal, paying taxes and bringing up families therein. They have a status in Canada which should now be recognized as deserving consideration as Canadian citizens who, during their war service fought in the same armies, shared the same dangers and were subjected to the same strains as members of the C.E.F. Imperial veterans who now require means of subsistence on the lines of war veteran's allowance would be approximately 2,500, or about 3 per cent of those settled in Canada.

Had these Imperial ex-service men remained in the United Kingdom, they would have been entitled to all the social legislation available there. The benefits of that social legislation are also available to a Canadian born veteran resident in the United Kingdom. Canadian born veterans resident in the United

Kingdom can even qualify for a non-contributory old age pension provided they have been resident in the United Kingdom for an aggregate period of not less than twelve years since attaining the age of fifty. On the other hand, foreign born residents must qualify by twenty years' residence.

There is, of course, no veteran legislation in Great Britain comparable to the war veterans' allowance, mainly because social legislation was in existence prior to the Great War and was readily adaptable to meet post-war conditions. We feel that it would be in the nature of a reciprocating measure if the benefits of the War Veteran's Allowance Act should now be made available to Imperials in this country who have a reasonable period of residence. Such reciprocal arrangements are in existence between some dominions of the British commonwealth, and other parts of the British Empire would no doubt have completed similar arrangements but for the present war.

Imperial ex-service men receiving disability or service pensions are in a particularly unhappy position, because British pensions are based on the cost of living in the United Kingdom and are generally lower than Canadian rates. In addition, they suffer heavily from exchange. There are many ex-Imperials in Canada now unemployable, who are attempting to exist on £1 or \$4.43 per week (if single) and £2 or \$8.86 per week (if married). These men rightly look to their comrades of the C.E.F. to support their plea for some better measure of social security than has hitherto been available to them.

Generous treatment to veterans in old age

So far in this brief we have dealt mainly with social security rates, believing that only by providing an adequate income to all citizens can we abolish want. We ask that this be done immediately for ex-service men because legislation already exists under which this can be accomplished. We further believe that this method of taking care of the veteran in old age should be continued, notwithstanding any social security measures that may be provided for non-veterans. A man who has borne arms for his country in time of war should receive more generous treatment in the country's social security plans than others.

General provision for retirement

If the present discriminations between those entitled to look to the federal government for social security and those who must obtain whatever is available to a civilian are to remain, then a large number of ex-service men will be keenly interested in the government's social security program.

The Legion believes a compulsory old age insurance plan should be adopted as early as possible. In the meantime some adequate interim legislation will be necessary so that those who will be unable to earn a retirement pension can be taken care of. Large numbers of ex-service men are in this class at present. The rates for this legislation must also be adequate for the purpose. There should be no degrees in the basic living standards among those who can no longer be employed, be they veterans or civilians. Therefore, an adequate basic rate should be struck which should be uniform in effect throughout the Dominion. Furthermore, there should be a reciprocal arrangement between the provinces and the federal government so that residence in any part of the dominion will be acceptable in any province.

Health insurance

It is our belief that if we can abolish want the health of our people will improve. In our opinion insurance against much sickness begins with the removal of want and the fear it induces. We therefore advocate the introduction of all those measures that will provide an adequate maintenance standard of living for all, including health insurance. But our view is that veteran needs should be the first charge upon the medical services of the country and that

treatment for war disabilities should not become merged in a general health insurance scheme. There will be those among the veteran community who will be entitled for many years to come to treatment from the Department of Pensions and National Health for disabilities and other conditions, according to regulations. All others will no doubt participate in whatever scheme parliament finally decides is appropriate for this country.

In this connection, the Legion desires to express approval of a compulsory, contributory national health insurance scheme, provided some benefits accrue to all who participate when in need. We believe that certain safeguards to personal liberty should be definitely incorporated in the legislation. An individual should be entitled to receive the kind of established treatment that he believes would contribute most to his health or his recovery from sickness. Any attempt to rigidly supervise persons or families in health matters, or to confine benefits only to such as can be supplied by one school of medicine would be resented by a considerable portion of the population. If participation in health insurance is to be compulsory, then we suggest that, where treatment is required or desired from sources not at present recognized by the proposed Act, a cash benefit should be made available so that this treatment can be sought privately, excepting only in cases of contagious disease. These safeguards to personal liberty can no doubt be worked out with provincial governments, most of whom already recognize in some measure in legislative form a citizen's right to choose his own method of treatment.

Unemployment Insurance

The Legion has always approved of a contributory system of unemployment insurance. However, as a social security measure the Act now in operation falls short, in that it excludes many classes of employed persons who should be included if it is to form part of a comprehensive scheme. Unemployment insurance without a retirement benefit is incomplete.

.....

In concluding this brief on behalf of the Legion we would summarize our views and recommendations as follows:—

- (1) That the Legion is in favour of compulsory contributory social security measures for all citizens, irrespective of place of residence within the dominion, to include unemployment insurance, provision for retirement, health insurance and provision for funeral expenses.
- (2) That there should be provision made by the state for children's allowances, and marriage and maternity benefits.
- (3) That provision should be made for a comprehensive scheme of workmen's compensation for Canada.
That implies the getting together with the provinces, and in so far as possible ironing out the different inconsistencies in the different Workmen's Compensation Acts.
- (4) That social security rates should be established for all parts of Canada sufficient to abolish want, and definitely linked with the cost-of-living index and varied accordingly.
- (5) That men who have borne arms in war-time should receive special consideration, not only in respect to re-establishment measures, but also, when they are no longer able to work, through the War Veterans' Allowance Act.

(6) That social security on an adequate scale should be made immediately available to all Canadian veterans, when unemployable, and to Imperial veterans who served in an actual theatre of war after an appropriate period of residence in Canada. The existing legislation for this is the War Veterans' Allowance Act.

(7) That the basic rates of war veterans' allowance should adequately provide for the necessities of life and be established on some scientific basis. In this connection, the Legion's Winnipeg convention proposal, the references to subsistence budget requirements in the Marsh Report, together with the rates established by the government for subsistence to discharged men during the post-war years, provide sufficient material upon which to arrive at a conclusion.

(8) That if health insurance is to be compulsory, then provision should be made for those who desire treatment from unorthodox sources.

(9) That immediate steps be taken to provide adequate children's allowances to recipients of war veterans' allowance.

(10) That steps should be taken to prevent jurisdictional problems which may arise between federal and provincial governments from retarding social security measures being made applicable throughout the dominion, particularly as they affect ex-service men.

The Legion and no doubt all members of this committee also have been profoundly impressed by the Beveridge report and the report presented by Dr. Marsh. We believe that there will be little disagreement with the fundamental objectives. The introduction of adequate contributory social security measures will establish the economic freedom of our people and will remove much of the cause of bitterness and strife in our internal affairs. To destroy fear of want will release much thought and energy for constructive purposes which might otherwise be consumed in depressed thinking and negative inaction.

We do not agree that planning for social security should be left until after the war. It should form part of the general reconstruction effort. In this connection we would direct the attention of the committee to the brief submitted by the Legion to the Committee on Reconstruction and Re-establishment.

REHABILITATION BENEFITS AND GRANTS (P.C. 7633)
(As amended by P.C. 2/3241, effective May 1, 1943)

BASIC RATE—Out-of-work Benefits; Training, Agricultural, Convalescent and Educational Grants for Non-Pensioners:—

	Single—no dependents	Man and wife only		One child		Two children		Three children		Four children		Five children		Six children	
		\$	cts.	\$	cts.	\$	cts.	\$	cts.	\$	cts.	\$	cts.	\$	cts.
	\$44.20 per month (\$10.20 per week)	\$62.40	per month (\$14.40 per week)	74	40	86	40	96	40	104	40	112	40	120	40

(Allowance for DEPENDENT PARENT solely or mainly maintained by dischargee, \$15 per month.)

CEILING OF INCOME FOR PENSIONERS WHILE TAKING TRAINING (VOCATIONAL OR EDUCATIONAL):—

Disability per cent	Single no dependents			Man and wife only			One child	Two children			Three children	Four children			Five children	Six children		
	Pension		Total	Grant		Total		Total		Total		Total		Total		Total		Total
	\$	cts.	\$	\$	cts.	\$	\$	\$	cts.	\$	\$	\$	cts.	\$	\$	\$	cts.	\$
5	3 75	44 20	47 95	5 00	62 40	67 40	79 40	91 40	101 40	109 40	101 40	109 40	109 40	117 40	125 40	125 40	125 40	125 40
10	7 50	44 20	51 70	10 00	62 40	72 40	84 40	96 40	106 40	114 40	106 40	114 40	114 40	122 40	130 40	130 40	130 40	130 40
15	11 25	43 75	55 00	15 00	60 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
20	15 00	40 00	55 00	20 00	55 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
25	18 75	36 25	55 00	25 00	50 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
30	22 50	32 50	55 00	30 00	45 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
35	26 25	28 75	55 00	35 00	40 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
40	30 00	25 00	55 00	40 00	35 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
45	33 75	21 25	55 00	45 00	30 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
50	37 50	17 50	55 00	50 00	25 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
55	41 25	13 75	55 00	55 00	20 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
60	45 00	11 25	56 25	60 00	15 00	75 00	87 00	99 00	109 00	117 00	109 00	117 00	117 00	125 00	133 00	133 00	133 00	133 00
65	48 75	12 19	60 94	65 00	16 25	81 25	93 25	105 25	115 25	123 25	115 25	123 25	123 25	131 25	139 25	139 25	139 25	139 25
70	52 50	13 12	65 62	70 00	17 50	87 50	99 50	111 50	121 50	129 50	121 50	129 50	129 50	137 50	145 50	145 50	145 50	145 50
75	56 25	14 06	70 31	75 00	18 75	93 75	105 75	117 75	127 75	135 75	127 75	135 75	135 75	143 75	151 75	151 75	151 75	151 75
80	60 00	15 00	75 00	80 00	20 00	100 00	112 00	124 00	134 00	142 00	134 00	142 00	142 00	150 00	158 00	158 00	158 00	158 00
85	63 75	15 94	79 69	85 00	21 25	106 25	119 00	130 25	140 25	148 25	140 25	148 25	148 25	156 25	164 25	164 25	164 25	164 25
90	67 50	16 87	84 37	90 00	22 50	112 50	126 00	136 50	146 50	154 50	146 50	154 50	154 50	162 50	170 50	170 50	170 50	170 50
95	71 25	17 81	89 06	95 00	23 75	118 75	133 00	143 75	152 75	160 75	152 75	160 75	160 75	168 75	176 75	176 75	176 75	176 75
100	75 00	18 75	93 75	100 00	25 00	125 00	140 00	149 00	159 00	167 00	159 00	167 00	167 00	175 00	183 00	183 00	183 00	183 00

The CHAIRMAN: Thank you, Colonel Nicholson. Are there any questions for Colonel Nicholson?

By Mr. Shaw:

Q. I wish to refer to page 9 where you refer to the benefits for veterans whether they served in an actual theatre of war or not. It is argued that men who went overseas and were kept in England were willing, of course, to make any sacrifice they were called upon to make. On page 15 when you refer to the Imperial veterans, you confine your recommendation to those who served in an actual theatre of war. Would there be any particular reason for that restriction being imposed upon the Imperial veteran, that he would have had to see service in an actual theatre of war before benefiting under our scheme?

Hon. Mr. MACKENZIE: The fundamental difficulty in granting the request of the Legion, extending over many years, to make the War Veterans Allowance Act available for Imperials who were resident in Canada before a certain date is that our own men are only eligible if they served in a theatre of actual war up to now, and the feeling in Canada amongst many has been that you cannot give the benefit of the War Veterans Allowance Act to Imperials even if they served in an actual theatre of war if you do not give the benefit to our own people who served in Canada and England. My own opinion is that you cannot extend it to Imperials who served in an actual theatre of war until you extend it to all Canadians regardless of where they served.

Mr. GERSHAW: On page 14 you state, "if participation in health insurance is to be compulsory, then we suggest that, where treatment is required or desired from sources not at present recognized by the proposed Act..."—I presume that refers to someone other than a practitioner—"...a cash benefit should be made available so that this treatment can be sought privately, excepting only in cases of contagious disease." I should like to ask if the guest speaker has given some thought as to what amount that should be? Would it be the amount that the individual has contributed or would it be an amount sufficient to cover the benefits which he wishes to secure?

The WITNESS: I think it would be based on the amount which would be allowed to a practitioner acting under the scheme, and would be on a basis comparable to what any other person would receive.

The CHAIRMAN: Captain Kermack, would you care to add something to what Colonel Nicholson has said? Do you represent the Imperial division?

CAPTAIN GEORGE KERMACK representing the Imperial Division of the Canadian Legion of the British Empire Service League, called.

The WITNESS: Mr. Chairman, Mr. Minister, and gentlemen, as your committee has under consideration a wide survey relating to social security affecting the whole civil population of Canada, we feel it is essential to place briefly before the committee the present serious position of some 2,500 Imperial ex-service men, some of whom are married, who have been settled in Canada for a considerable length of time and whose need is urgent. We also propose to submit a few observations with regard to the position of Imperial ex-service men and women who may migrate to Canada after their service in the present war.

Ex-Imperials of Previous Wars

Unsuccessful attempts have been made to obtain for these Imperials who have had service in a theatre of actual war or have sustained disabilities on war service the benefits of the War Veterans' Allowance Act, provided they resided in Canada on or before 1st September, 1930, when the War Veterans' Allowance Act came into force, and who have since resided in Canada.

Imperials have regarded that proposal as fair and just and are unable to appreciate the value of any argument which has been advanced against it.

The present position is that Imperials who may have been resident in Canada since any time after 1902, when their service in the South African War terminated—that is any number of years up to 40 years as at the present time, or after the armistice in November, 1918, that is any number of years up to 24 years—are refused the benefits of this social legislation.

It is useful to contrast this with the reciprocity accorded by the United Kingdom in social legislation, and in particular with respect to non-contributory old age pension, for which purpose a Canadian-born citizen may qualify by an aggregate period of 12 years residence after reaching the age of 50.

The material points on this question appear to be as follows:—

1. The War Veterans' Allowance Act is social legislation enacted 11 years after the last shot was fired in the First Great War.

2. The Act was designed to meet a condition of disability or inability to maintain themselves on the part of Veterans (as defined by the Act) who either had served during the First Great War in a theatre of actual war or who are in receipt of pensions for injury or disease incurred or aggravated during service in that war or who have accepted final payments in lieu of annual pensions in respect of such disabilities rated at 5 per cent or more of total disability.

It is clear that the primary conditions of eligibility under the Act are (1) service in a theatre of actual war, and (2) receipt of disability pension or of a final payment as outlined above, and that unless one of these conditions is satisfied there can be no award of allowance. In other words, the "burnt-out" condition is not there. It is true that there are other conditions to be examined before an award can be made but these deal with the age, condition and circumstances of the applicant.

In the circumstances we have outlined, which we believe show a clear case for the obvious remedy, there is a matter of principle involved of equality of treatment and the numbers of those likely to be benefited are not truly of first concern. It may be noted, however, that the number is around 2,500, or about 3 per cent of the Imperials resident in Canada.

It is a further argument in favour of our proposal, that Canadian citizens in the United Kingdom receive benefits under social legislation there, while Imperials resident in Canada have lost the benefits of that social legislation.

As to the present position of these Imperials we have specially referred to, it may be sufficient to say that there are hundreds of ex-regular soldiers of the British army now resident in Canada who are attempting to exist on the following income from all sources:—

(a) If single, £1 or \$4.43 per week.

(b) If married, £2 or \$8.86 per week.

How many there may be with smaller incomes we cannot pretend to estimate.

In this connection we refer to pages 3 and 4 of the brief of the Canadian Legion submitted to your committee to-day with reference to rates of relief and unemployment assistance and Social Security in terms of necessities of life, and also to pages 6 and 7 of the same brief with reference to rates under the War Veterans' Allowance Act. Comparison seems unnecessary.

We earnestly submit for the consideration of your committee the sad plight of this small body of Imperials.

To put the situation in greater detail before your committee, we are filing copies of:—

1. Our presentation to the Special Parliamentary Committee on Soldiers' Affairs in May, 1941.

2. Memorandum prepared by the Imperial Division in September, 1941, with reference to the number of Imperials resident in Canada who would benefit by our proposal under the War Veterans' Allowance Act. The figures in this memorandum are subject to deduction in respect of the death rate since 1940 and also in respect of the number who have obtained employment which would have been beyond their reach but for the present war conditions.

3. Summary of the position, prepared by the Imperial Division in March, 1943.

Immigration of Imperials Serving in the Present War

We believe that many of our comrades of the British armed forces in this war will seek to settle in Canada after their war service is over, and in that connection we respectfully submit to your committee the great importance of making arrangements at the earliest possible date for the welfare of these men and women on the following lines:—

Reciprocity between the United Kingdom and Canada, and, it may be, also reciprocity between other dominions of the British Commonwealth and Canada, with reference to national insurance rights and the benefits thereunder, such as national health, widows, orphans and invalid pensions, workmen's compensation, contributory and non-contributory old age pensions.

Under British health insurance legislation, arrangements are possible with other dominions of the empire to secure the continuity of insurance of persons who, being insured in Great Britain, are or become resident and employed in another dominion with which such an arrangement is made.

Such arrangements have been made between Great Britain and Ireland; between Great Britain and the Isle of Man and between Australia and New Zealand. Arrangement on the same lines between the United Kingdom and Canada with regard to immigrants during and after the present war would, it is believed, smooth the path of Imperials settling in Canada.

Conclusion

Imperial veterans in Canada regard themselves in the fullest possible sense as Canadian citizens, they have their families here and are more content to be here. It is a natural desire on their part that they should wish to see that the welfare of their comrades who are in distress received the fullest possible consideration under the system of democracy for which they and many of their children have given and are giving unrestricted service in times of war.

The CHAIRMAN: Thank you, Captain Kermack. Are there any questions?

Mr. JOHNSTON: Mr. Chairman, might I just make one reference to the first brief on page 16: "The introduction of adequate contributory social security measures will establish the economic freedom of our people and will remove much of the cause of bitterness and strife in our internal affairs." May I ask this question: why does the veterans' organization stress the contributory part further than the non-contributory part?

Colonel NICHOLSON: We feel that if this is going to be a national scheme it is not something which should be borne solely by the state but that everybody who benefits from it should work for it and should contribute to it.

Mr. JOHNSTON: Do you not think that if it is going to be a national scheme everybody should come under it whether they are able or not? By mentioning the contributory part you have only those who are financially able to contribute. It seems to me to be an injustice to some people. I should prefer a non-contributory to a contributory scheme.

Colonel NICHOLSON: No, I think we are set on the contributory scheme. We feel that if a man is able to work he should contribute.

Mr. JOHNSTON: That is not what you say here; you say whether he is able or not he must contribute; that is the point of difference.

Colonel NICHOLSON: Well, as far as the unemployment provisions are concerned, when he is not working naturally he cannot contribute and he is a care, but if he is working then he should contribute. I do not know whether that answers your question.

Mr. SHAW: You believe that everybody should be covered?

Colonel NICHOLSON: Yes.

Mr. JOHNSTON: You should qualify it in this report so that if he is able to contribute he should contribute. You have stated that there should be a contributory method, and you do not qualify that statement in your brief. If your recent statement were in that it would not be quite so bad.

Mr. HERWIG: Excepting that we ask that war veterans' allowances be made applicable to all Canadians, and that is not a contributory scheme at all. We recognize the difference between the employable and the unemployable, and the unemployable must be taken care of.

Hon. Mr. MACKENZIE: May I refer for a moment to Mr. Kermack's brief:

The present position is that Imperials who may have been resident in Canada since any time after 1902, when their service in the South African war terminated—that is any number of years up to forty years as at the present time, or after the armistice in November, 1918, that is any number of years up to twenty-four years—are refused the benefits of this social legislation.

There are quite a number of Imperials to-day who were in Canada before 1914 who are in receipt of veterans' allowances—about 400.

The WITNESS: I am talking about those who cannot get the consideration because they were not here before the South African war.

Hon. Mr. MACKENZIE: The paragraph is misleading, to my mind. The Imperials who were domiciled in Canada before the great war are entitled.

The WITNESS: Oh, yes. I thought the inference was clear; if they served in a theatre of war in the great war. I am sorry if I did not make that clear.

Hon. Mr. MACKENZIE: It is clear now. My second point I will direct to Colonel Nicholson who presented a very able brief, as good as the one which the Legion presented before the reconstruction committee recently. It is one of the best we have heard. Now, was your submission that ex-servicemen should not be included under the general coverage of health insurance, or was it not rather that these special benefits, by way of treatment and otherwise, which they receive from legislation already enacted, or will receive from legislation

yet to be enacted, should not be taken away; in other words, that they be protected in regard to all special measures passed on their behalf? You must remember, of course, that their dependents would be protected under the general national scheme of health insurance but their dependents are not necessarily protected in every case by statutory enactments already in force.

Colonel NICHOLSON: Yes, that is right.

The CHAIRMAN: Colonel Nicholson, the committee is very grateful to you and Captain Kermack and members of your association for your presentation here to-day.

The committee adjourned to meet Thursday, July 8, at 11 o'clock a.m.

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Canada Social Security
- Bill - 1943

SESSION 1943
HOUSE OF COMMONS

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SPECIAL COMMITTEE

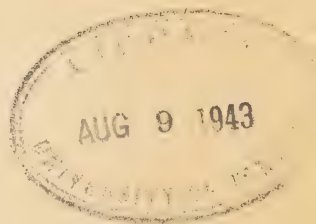
ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 27

TUESDAY, JULY 13, 1943
WEDNESDAY, JULY 14, 1943
THURSDAY, JULY 15, 1943



OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1943

MINUTES OF PROCEEDINGS

TUESDAY, July 13, 1943.

The Special Committee on Social Security met this day at 11.30 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Breithaupt, Coté, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McGarry, Shaw, Warren and Wright—20.

In attendance were: Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health; Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health.

On motion of Mr. Breithaupt, the Committee proceeded to consider a Draft Bill intituled "An Act to establish a National Council on Physical Fitness".

With the exception of Clause 2(e), which was deleted, all the other clauses of the Draft Bill and the title were adopted, and it was agreed to report the Draft Bill to the House.

A general discussion of the Health Insurance Bill followed.

With respect to Clause 35(2), it was suggested that the words "The Chairman" be deleted and the words "One member" be substituted therefor.

The Committee adjourned at 1.00 o'clock, p.m. to meet again on Wednesday, July 14 at 4.00 o'clock, p.m.

WEDNESDAY, July 14, 1943.

The Special Committee on Social Security met this day at 4.00 o'clock, p.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Casselman (*Mrs.*), (*Edmonton East*), Fauteux, Fulford, Gershaw, Howden, Johnston (*Bow River*), Macmillan, McGarry, Warren and Wood.

In attendance were: Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health; Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health; Mr. A. D. Watson, Chief Actuary, Department of Insurance; Professor S. A. Cudmore, Dominion Statistician, Dominion Bureau of Statistics; Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics; Mr. S. B. Smith, Chief, Business Statistics, Dominion Bureau of Statistics; Colonel J. R. Munroe, Chief, Finance Statistics, Dominion Bureau of Statistics; Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics.

A number of the members desired to attend the proceedings taking place in the House so the Committee adjourned to meet again Thursday, July 15, at 11.30 a.m.

THURSDAY, July 15, 1943.

The Special Committee on Social Security met this day at 11.30 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Adamson, Breithaupt, Bruce, Casselman, (Mrs.), (Edmonton East), Claxton, Coté, Gershaw, Gregory, Howden, Johnston (Bow River), Kinley, MacInnis, MacKinnon (Kootenay East), Macmillan, McCann, McGarry, Mayhew, Shaw and Wood—19.

In attendance were: Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health; Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health; Mr. A. D. Watson, Chief Actuary, Department of Insurance; Professor S. A. Cudmore, Dominion Statistician, Dominion Bureau of Statistics; Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics; Mr. S. B. Smith, Chief, Business Statistics, Dominion Bureau of Statistics; Colonel J. R. Munroe, Chief, Finance Statistics, Dominion Bureau of Statistics; Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics.

The Chairman filed a letter from Mr. F. A. Robinson, on behalf of the Missions of Biblical Education, Toronto, protesting against medical dictatorship. Also an enclosed pamphlet entitled "How My Body Became Its Own Physician".

A brief from Mr. A. B. Davies supplementary to the evidence he gave on June 10 before this Committee was ordered printed in the evidence.

A memorandum on Housing submitted by Dr. Heagerty at the request of the Committee, was ordered to be printed in the evidence.

The Committee proceeded to consider the clauses of the draft bill.

Clause 2 (a), (b) and (c)—adopted.

Clause 3 was considered and deferred pending revision of First Schedule which relates to same.

The Committee adjourned at 1.00 o'clock, p.m., to meet again Friday, July 16, at 11.30 a.m.

J. P. DOYLE,
Clerk of the Committee.

RE: SUPPLEMENTARY EVIDENCE TO THE ORAL REPRESENTATIONS
OF A. B. DAVIES. DELIVERED ON JUNE 10, 1943

(MINUTES OF PROCEEDINGS NO. 19, PAGES 567 AND 568)

I beg you humbly to allow this additional brief, to be added to my above enumerated evidence, the contents of which I deem of *vital importance* to the public interest of our country.

If Dr. J. J. Heagerty's evidence, recorded in the Minutes of Proceedings No. 2, page 58, dated Friday, March 19, 1943, can be taken as a criterion, *every medical practitioner in our country will receive \$10,000 annually* from our public funds, yet only a portion of their services will be subsidized...

It appears unbelievable, spurious and impossible, but we cannot deny the fact that I am merely quoting Dr. Heagerty, who, as stated above, gave evidence

before you to this effect saying "...42 per cent of the moneys expended for medical care in the United States goes to the Doctor; in Canada approximately 44 per cent..." and if we believe in figures, 44 per cent of the total amount asked for medical care, annually, in Canada is \$105,600,000, which divided among the total number of medical practitioners in our country (10,500) will exact for each one a net grant of over \$10,000, without however, conscripting their full time services.

Again, according to Dr. Heagerty (Minutes of Evidence No. 2, page 56), the National Health Insurance scheme proposed now to you for study and ratification, is practically a repetition of the similar Health Insurance, practised in England since 1912; though again Dr. Heagerty himself, stated in his same evidence on pages 47 and 55 respectively that "...It has been demonstrated that there has been no improvement in the Health of the British people through health insurance, since it was introduced in England, put into effect in the year 1912" and again (page 55) "...As I indicated at the outset, in England *there are just as many people coming up to-day for medical care, as in 1912* when the scheme went into effect..." In other words, honourable gentlemen, you are asked to sanction an annual subsidy for medical care to the amount of \$240,000,000, and to pay enough so that if the granted amount be apportioned equally among all the medical practitioners in the country, each shall receive \$10,000 a year, *for either repeating a positively proven failure of 30 years' standing (the British plan of health insurance) or for the perpetuation of an equally proven failure (the status quo of health services now in operation)* as the Honourable Minister of Health gave you to understand in his evidence of March 16, 1943 (Minutes of Proceedings, No. 1, page 30, paragraphs 3 and 4) I quote: "...The Committee's purpose has been to disturb the normal existing arrangement and customs of the people as little as possible..." As provided for in the recommended scheme, *the sick person will, as now, see the physician of his choice. The family doctor may call in a specialist if necessary, and may order nursing attendance or hospitalization, and he may prescribe medicines, or other treatment facilities*" and the following paragraph *"the big difference will be that the doctor, the nurse and the hospital will send their bills to the health insurance fund instead of to the patient."*

Dominion vital statistics, recorded in the Canada Year Books of 1920 and 1942 definitely show that though our population is practically the same now as then, yet, our hospitals have increased 70 per cent, our regular and mental patients in our health institutions have increased 480 per cent and their expenditures 800 per cent. Should the requested grant of \$240,000,000 be legislated, then the expenditure for health services will be increased 1000 per cent. *This is the record which our various health authorities are boasting about and presenting to you as their only guarantee for the gigantic amount asked for caring for the sick of our country...*

In conclusion, honourable gentlemen, allow me to emphasize and remind you kindly, the evidence of Mr. Herbert Hannam, the president of Canadian Federation of Agriculture (who so selflessly and devotedly worked for the success of socialized health services in our country) read to you on the same day as my evidence (June 10, 1943) also Honourable George Hoadley's "Canada's Health", who also worked so wonderfully with Mr. Hannam for socialized health services, both of which so graphically depict medical services in our country as being utterly inadequate, even deplorable and almost repulsive. Who (our medical practitioners), can easily forget our country's 23,000 annual deaths from cancer and 34,000 deaths from heart diseases and are asking you to allow them to poison the bloodstream of *every Canadian*, with an intent of preventing either the 180 deaths from smallpox, or 214 deaths from diphtheria, yet *never attempting to do anything to prevent either cancer or heart diseases*. Who, like the Brahmins of India, holding themselves out as a privileged class,

aloof of all possible equality with the rest of us, now refuse to submit themselves to the authority of our legally elected government. Therefore I humbly submit, that you kindly recommend to our Parliament that since the services of medical practitioners are now in demand for the successful culmination of our war efforts, *their services be conscripted and each of them be given a stipulated wage to carry on caring for the sick*, as our armed forces are carrying on the fight against totalitarian doctrines and authorities at the present time.

Very respectfully yours,

(Sgd.)

A. B. DAVIES.

HAMILTON, ONT., July 10, 1943.

Box 200, Station B.

HOUSING AND HEALTH

DR. J. J. HEAGERTY

Director, Public Health Services, Department of Pensions and National Health

The following figures indicate the influence of bad housing upon the death rate:—

DEATH RATES, ETC., IN DIFFERENT AREAS OF THE SAME TOWN

Birmingham (5 years)

	Bad area	Fair artisan area
Population	154,662	133,623
Area (in acres)	1,921	2,998
Death-rate	21.1	12.3
Birth-rate	32.8	24.0
Infant-mortality rate	171	89
Deaths from pulmonary tuberculosis.....	1,511	742
Pulmonary tuberculosis death-rate	1.93	1.11
Deaths from measles	647	161
Measles death-rate	0.83	0.24
Deaths from diarrhoea and enteritis	1,126	238
Diarrhoea and enteritis death-rate	1.46	0.36

Liverpool (5 years)

	Bad area	Another populous area with large artisan population
Population	44,616	85,118
Area (in acres)	391	675
Families or separate occupiers	9,802	17,939
Death-rate	27.5	17.8
Birth-rate	38.9	29.5
Infant-mortality	164	123
Pulmonary tuberculosis death-rate (3 years)	2.14	1.73
Measles death-rate (3 years)	1.10	0.32
Diarrhoea and enteritis death-rate (3 years).....	3.17	1.00

Manchester (5 years)

	Bad area	Populous area, mainly artisan
Population	88,737	86,299
Area (in acres)	898	3,252
Death-rate	23.86	12.93
Birth-rate	29.01	21.77
Infant-mortality rate	166.3	111.57
Pulmonary tuberculosis death-rate	3.32	1.07
Measles death-rate	0.85	0.30
Diarrhoea and enteritis death under 2 years of age per 1,000 births	49.30	20.01

London (5 years)

	Bad area	Mainly artisan area
Population	111,390	121,376
Area (in acres)	658	8,277
Death-rate	18.6	12.4
Birth-rate	32.1	23.4
Infant-mortality rate	147	83
Pulmonary tuberculosis death-rate	1.81	1.27
Measles death-rate	0.92	0.24
Diarrhoea and enteritis death-rate	1.47	0.36

Aberdeen (1911 and 1912 combined)

	Rubishaw	Greyfriars
Population	20,210	13,850
Death-rate	10.2	16.3
Birth-rate	16.2	34.1
Infant-mortality rate	83	170
Excess of births over deaths	6.0	17.8
Death-rate per 1,000:—		
Zymotic disease	0.8	3.1
Pulmonary tuberculosis	0.6	1.3
Other forms of tuberculosis	0.2	0.7

These figures indicate that the death rate in slum areas is nearly twice as high as for the rest of the city. It is not possible to estimate the harm that results from the high death rate alone. One must take into consideration the increased incidence of disease in slum areas and the poor physique of slum dwellers. The former is extremely high and the latter lower than the standard for the rest of the community. If we consider the old portions of any large city, it will be almost invariably found that the morbidity and mortality rates have always been much higher than in newer districts. If it were possible to remove all slum dwellings in all cities, many thousands of lives would be saved each year, notably of children, and the incidence of disease would be very greatly reduced. It is unfortunately true that dwellers in slum areas are only too often industrial workers who spend their day in a dusty, ill-lighted and badly ventilated factory. Invariably, they and their families show a high incidence of disease and a high mortality. Efforts have been made to ascertain the wastage of life ascribed to slums. It is estimated that, in the slum areas of London and the county burroughs of England, there is among the twenty million of people living in these towns an annual loss of 50,000 lives which should not occur, this loss being over and above the mortality in other areas.

In Glasgow, it was customary for the poor to live in one or two roomed houses in tenement buildings. Housing schemes have helped to improve conditions, but a few years back over sixty per cent of the whole population lived under such conditions. The Medical Health Officer of the city, Dr. Chalmers, reported mortality rates in these houses as follows:

	Death-rate per 1,000
One-roomed houses	25.9
Two-roomed houses	16.5
Three-roomed houses	11.5
Four-roomed houses	10.8

That is to say, the death-rate in one-roomed houses was three times as great as in three-roomed houses.

The general death-rate in slum areas is nearly double, the infant mortality rate double, the death-rate from tuberculosis more than double, from measles three times as high and from diarrhoea and enteritis three times as high as in healthy areas. A reference to the preceding figures given for Birmingham, Liverpool, London, Manchester and Aberdeen shows this quite clearly.

There is every evidence that the elimination of slum districts in cities and the provision of better houses would have a very distinct effect on the future health of the population.

The most marked indication of the effect of poor housing is shown in infant mortality, pulmonary tuberculosis, diphtheria, scarlet fever and other diseases.

The United States Children's Bureau, from a study of 23,000 records of births in eight cities in the States, found that "the infant death-rate in families which lived in homes with two or more persons per room was two and a half times that in families which lived in homes with less than one person per room. The variations in mortality from gastric, intestinal and respiratory diseases were especially marked."

The following is a summary of mortality rates in the city of Detroit for 1927:

Average number of persons per room	Infant deaths per 1,000 births	Death rates per 100,000 population			Deaths from all causes per 1,000
		Tuberculosis	Pneumonia	Diphtheria	
0.9 or more.....	86	132	113	22	10.9
0.8.....	69	79	87	17	9.5
0.7 or less.....	62	52	77	18	9.5

After adjustment of the 1930 death-rate for Cleveland, it was found that the death-rate for age and sex varied from 15 per 1,000 population in the lowest of the twelve areas to 7.2 per 1,000 of population in the highest economic areas. The lowest economic area represented the equivalent of \$20 per month rental and the highest \$75 or more per month. The excess mortality was in areas with a rental of less than \$40 per month. The mortality from tuberculosis (ages 25 to 44) varied from 215 per 100,000 population in the low rental area to 34 in the high. The infant mortality rate per 1,000 births was 110 in the low rental area, with an average rental of less than \$15 and decreased to 26 in the area with an average rental of \$100 and more.

In making these comparisons, one must take into consideration a number of factors, namely, density of population, race, tenement flats, proportion of dwellings, age distribution, marital conditions, unemployment, illiteracy, juvenile delinquency, birth-rate, etc.

Reverting to European data, we find the following recent comparison for Liverpool:

AVERAGE OF THE YEARS 1923 TO 1929

—	Population	Deaths from all causes per 1,000 population	Deaths from pulmonary tuberculosis per 100,000	Infant mortality per 1,000 births
Entire city.....	872,802	13.9	123	98
Corporation tenements.....	14,572	18.2	164	131
A slum area.....	3,436	28.4	299	171

It is pointed out that these figures take on additional significance when it is considered that the houses in the slum area are periodically visited by the sanitary staff of the city and nuisances abated. The streets and passageways are systematically cleaned, private drains are regularly flushed and baths, wash houses, and infant welfare centres and clinics provided. In other words,

apparently nothing short of demolition of these houses has any influence in reducing the death-rate.

The following figures are an indication of the effect of re-housing on the same sites for which the preceding figures were given in Liverpool as a part of the re-housing scheme; the same type of population is under consideration, since the new tenants are persons who had lived in the houses on the same sites:

	Deaths from all causes per 1,000 population	Deaths from phthisis per 1,000 population	Infant mortality per 1,000 births
Before reconstruction.....	37.0	4.0	259
After reconstruction.....	26.6	1.9	162
Entire city.....	18.0	1.7	119

The improvement is obvious.

A low level of sanitation is one of the chief factors in the high death-rate. The disposal of sewage through a water-carriage system is of as great importance as the water supply. Many cities to-day have not a complete water-carriage system. For example, of 386 families in a slum area in New York (1933), 267, or 69 per cent, did not have toilets in their flats. The use of a single toilet for a number of families is a health hazard.

The chief factor, however, in the causation of disease in the slum area is overcrowding. The income of the average inhabitant is small and he and his family are obliged to live in quarters that are too small. Some years ago, in certain large Canadian cities, rooming-house keepers rented a room containing half a dozen single beds to as many as a dozen foreign labourers. The beds were occupied in shifts; half a dozen occupying the beds by day and a similar number by night. There was no change of bed linen as the occupants of the beds did not undress.

Overcrowding is not so great as it was fifty or more years ago, when immigrants flocked to the cities, and the health hazard is, therefore, not quite so great, at least for adults.

That the ill effects of bad housing, overcrowding and bad sanitation are not altogether something of the remote past is shown by the great epidemics of typhus and relapsing fever from 1919 to 1923. It is said that "in 1920, five and a half million cases of these diseases were reported in European Russia and Ukraine. From 1919 to 1923, thirteen million were reported."

A survey of industrial cities in New York State elicited the fact that seventeen per cent of the buildings had dark rooms. These had no outside windows or even a window in an interior hall to admit light and air.

Absence of ventilation has long been known to play a part in the incidence of tuberculosis. The incidence of tuberculosis in Keighley, England, was three times as great in back-to-back houses as in houses with proper ventilation.

In considering these figures, one must not forget that there is a tendency for the tuberculous, through lack of earning capacity, to drift into the poorer districts.

It is not possible to show consistent improvement in health statistics where people have been moved from slum areas to healthy areas, but a comprehensive analysis does indicate a decrease in morbidity and mortality.

Cerebro-spinal meningitis is particularly associated with overcrowding and the carrier rate is much higher in overcrowded areas.

The slum area is a menace inasmuch as contagious diseases are apt to be communicated to the healthy districts.

From Professor Irving Fisher, of Yale, we learn that there are 3,000,000 persons in the United States at all times suffering from some form of sickness (equal to approximately 300,000 in Canada) of whom about 1,100,000 are in the working period of life, three-quarters being actual workers who must lose at least \$700 a year, making an aggregate loss from illness of \$550,000,000. The expense of medicine, medical attendance, extra foods, etc., would equal this amount; thus, we have the total cost of illness as \$1,100,000,000, of which it is assumed that at least one-half is preventable. The sick man is a burden to the community whilst the healthy man is an asset. The one has to be carried, the other carries his own burdens and helps to carry the burdens of others. The worker living in a slum area is unduly exposed to disease.

It has been well said that "tuberculosis is the disease of darkness". Slum spot maps match disease incidence. The maps indicating the highest infant death-rate, the highest tuberculosis death-rate, the greatest juvenile delinquency exactly match the spot map indicating the greatest congestion in housing accommodation. These subjects are so interrelated that they cannot possibly be separated. Where surveys have been made, it has been demonstrated that there is from 25 to 50 per cent more tuberculosis in tenement house districts of every city than in the individual homes. A study of two contrasting districts was made in Cleveland and one of the results was the showing in actual figures of the relationship of disease and death to insanitary dwellings. One district was in the old crowded business section of the city; the other was in the outlying section and near some manufacturing plants. The rents in both were practically the same. In the first district between 1907 and 1914 there were 908 cases of tuberculosis or 52 per thousand. In the second district there were 450 or 28 per thousand. In the first district there were 665 cases of contagious disease in 1912, or three per thousand. In the second, there were 286 cases or 1.29 per thousand. Evidence of the same character could be given for all the large cities in England, Scotland and the United States.

In estimating the cost of a housing program, consideration should be given to the loss caused by communicable diseases and the saving that would ensue by the control of such diseases.

The figures for Canadian cities, in so far as they are available, indicate that morbidity and mortality in slum areas are comparable with similar areas in the United States and Great Britain.

In Toronto, June, 1934, the number of cases of tuberculosis known to the Department of Public Health for the seven ward divisions of poor housing was 299, or 37 per ten thousand of population. This is in contrast to an incidence of 25 per ten thousand for the four districts of good housing. The highest rate, 64 per ten thousand of population, was reached in Ward 4, subdivision 3, which has the highest population density of any subdivision in the city. Seventy-five per cent of tuberculosis cases were cared for in the homes of the patients.

In 1927, the Montreal Anti-Tuberculosis and General Health League conducted a survey which showed that 63 per cent of tuberculosis cases had not a separate room and 50 per cent had not a separate bed. A special survey made in Halifax in 1932 disclosed an abnormal incidence of the disease in districts of bad housing.

The infant mortality rate of a community is controlled by many factors, and one of these, not least in importance, is housing. Infant mortality statistics furnished by the Department of Public Health in Toronto demonstrate this quite clearly. The infant mortality rate is the death rate for infants under one year computed per one thousand living births. For Toronto as a whole, in 1933, this was 63.4. For the seven areas of bad housing it was 72.6 and for the

four areas of good housing 58·3. In Ward 2, subdivision 2 (Moss Park) the rate was 121·2 which is almost double the rate for all Toronto; and in Ward 3, subdivision 6 (the Ward) it was 83·3.

Of recent years a great deal of study has been given to the housing problem in Canada. Among the studies made the following are of interest:—

Montreal

Within the past few years a great deal of attention has been given to the housing problem in the City of Montreal, largely as a result of the worthy efforts of the City Improvement League. The following studies have been made:—

1. A report on Housing and Slum Clearance by the Board of Trade and City Improvement League 1935.
2. Housing for the low-wage earner by the Montreal Council of Social Agencies 1936.
3. Housing conditions in Montreal by the Housing Committee of the Department of Planning and Research of the Montreal Metropolitan Commission 1937-38. The last named is a very comprehensive study of 4,216 dwellings in sixty city blocks wherein is found the greater part of the older housing. Contrary to expectations, very little overcrowding is noted. The principal housing evils disclosed are:—
 - (a) Absence of bathroom accommodation: only 32 per cent have a bathtub.
 - (b) Absence of hot water plumbing: only 11 per cent have hot water plumbing.
 - (c) Water closet installations in kitchen in 34 per cent of dwellings.
 - (d) Vermin infestation in 55 per cent of the dwellings.
 - (e) Permanent dampness in 9·8 per cent of dwellings.
 - (f) Indirect lighting in 9 per cent of total number of rooms.

It is interesting to note the reasons given by 2,195 people for their last removals, indicating an appreciation on their part of some of the housing evils. Thirty-four per cent moved because of the physical condition of the dwelling, 25 per cent on account of bad hygienic conditions, and 9 per cent because of the unsatisfactory environment. An estimate from the Department of Health shows that notwithstanding the closing of 500 unhealthy houses there remain 1,000 dwellings unfit for human habitation, and several thousand others badly in need of repairs required to make them meet the minimum standards of health.

Toronto

In a survey of Toronto which embraced 1,332 dwellings, it was found that 175 households occupied one or two rooms; 75 per cent of those occupied were unfit for human habitation; 59 per cent had no bath; and 202 had outside privies. The principal housing evils related to rear and alley dwellings, 900 of which were unfit for human habitation. As a result of the studies made relating to housing in the City of Toronto, it was resolved to form a Provincial Housing and Town Planning Association.

Hamilton

In 1937, the City of Hamilton passed a housing by-law which was the first attempt to provide a model housing law in Ontario.

Ottawa

In November, 1935, a report was made upon the housing of relief recipients in the City of Ottawa. The survey covered 3,529 self-contained dwellings comprising 5,625 housekeeping family units, housing nearly one-fifth of the city's total population. It was found that 1,527 sleeping rooms were overcrowded;

3,209 families were without a separate bath; 3,087 families were without a separate wash basin; 1,949 families were without a separate water closet; 814 families were without yard space; and 868 rooms were used both as bedroom and kitchen. In addition, the report showed that 576 houses were unfit for human habitation; 1,369 houses needed rehabilitation; and it was considered that 1,189 new dwellings were required to relieve the overcrowding.

Winnipeg

For thirty years the City of Winnipeg has been engaged in promoting better housing conditions. Three housing surveys have been made and each year a survey is undertaken to determine the relationship between available dwellings and marriages. The annual reports for the years 1935 and 1936 show that, although there were 5,313 marriages, the available housing accommodation for these newly married couples was only 180.

Edmonton

During the depression period from 1929 to 1939, building was practically at a standstill in Edmonton. During the same period the population increased from 74,298 to 90,419.

Since the beginning of the war, many soldiers' families have come to live in the city while the husband is overseas. Many others have come to take jobs in war industries. Added to all this, the past year has seen a tremendous influx of Americans. These latter are comprised of military personnel and large staffs of American civilian contractors who have business in the north.

In short, a housing situation which was very bad before the war has become rather a nightmare at the present time. People keeping house in garages, families living in one and two-roomed suites or in shacks which are altogether unfit for human habitation have become common. Two families with six children (one a girl of 16 years) were found living in a one-roomed shack. The health officer has refrained from condemning many of these living quarters only because he can find no other shelter for their occupants.

A census of the city population of Edmonton is now under way. The Federal Government has undertaken to build 250 wartime houses in Edmonton and already there are 750 applicants for these. Since the war, many of the larger city blocks have been divided into one and two roomed suites with a common bathroom for each floor. Not the least of the undesirable results is the crowding of teen age children into the same quarters with both sexes of their own and older ages. Dr. Little, Medical Officer of Health of Edmonton, remarks: "We are not making good citizens of many of these youngsters."

Calgary

The housing problem in the City of Calgary may be said to have arisen in the years 1930 and 1931 at the beginning of the depression. The majority of people lost their property and had to move into office blocks vacated on account of business and depression. These were altered into makeshift housekeeping suites. Those who could retain their property sub-divided it and, in many instances, what was a one-family dwelling bloomed into an eight-suite apartment. In time, due to lack of money, these became ramshackle and were condemned by the Engineer of the Health Department. The influx of members of the Armed Forces and their families into Calgary has not tended in any way to alleviate the situation but has acted as an incentive for a further number of one-family householders to sub-divide, again with injurious results. Dr. Hill, Medical Officer of Health of the City of Calgary, estimates that at the present time fifty per cent of the population of the City of Calgary are unsatisfactorily housed.

Province of Saskatchewan

There is much bad housing in both urban and rural areas in the Province of Saskatchewan. This does not consist merely of overcrowding but runs all the way from structural defects to lack of sanitary facilities. There are instances where two families of as many as seven people occupy one room fourteen feet square; a mother and five children living in a two-roomed shack through the walls of which daylight can be seen at almost any point; five families living in a storey and a half five-roomed house; three families occupying the basement which was intended only for the heating plant and fuel storage; three beds set up and occupied in the basement of an ordinary house without benefit of partitions, light, ventilation or sanitation.

In some of the urban centres, there is much overcrowding, many buildings being occupied as dwellings which are not fit for human habitation in their present state and some cannot be made suitable even if alterations were attempted.

Information from the city of Moose Jaw indicates that there is a shortage of about 250 houses in that city; Yorkton reports a shortage of at least 100 single-family dwellings; Estevan estimates that 22 per cent of homes now occupied would be condemned if good housing standards were enforced; Weyburn estimates a shortage of 50 homes; Swift Current reports a similar shortage; Saskatoon reports a very great shortage of self-contained suites.

It is estimated that 15,000 new homes are required in the province to provide suitable accommodation for persons married within the last five years alone.

Province of British Columbia

The situation in British Columbia reflects that of other provinces. There is lack of adequate accommodation in the city of Vancouver. During the depression houses were converted into one and two-roomed dwellings without adequate cooking or bathing facilities and conditions in basement dwellings were especially bad.

Halifax

The housing situation in the city of Halifax has received so much publicity since the outbreak of war that it does not require elaboration. Detailed information regarding pre-war housing in Halifax may be found in a study of housing conditions in that city made under the direction of the Citizens' Committee on Housing and published in a Report which includes the results of an investigation by A. G. Dalzell, M.E.I.C., and a sanitary survey by the City Board of Health.

Saint John

There is much room for improvement in the housing situation in the city of Saint John. A great many of the houses are old and many flats and dwellings overcrowded. The Province passed a modern Town Planning Act in 1936 which confers planning powers on any local authority. Since that year the cities of Fredericton and Saint John have appointed Town Planning Commissions.

* * *

Dr. R. St. J. MacDonald, Professor of Hygiene, McGill University, in an article entitled "Progress in Housing and Health", informs us as follows:—

Progress has also been made in the preparation, passing and enforcement of legislation designed to achieve better housing.

But it must be admitted—having regard to the economic side of the problem—there has not been much progress made in providing what is sorely and urgently needed, a sufficiency of low-rental houses for the low-salaried workers.

LACK OF PROGRESS

There has been a lack of progress with regard to two fundamental requirements in a better housing program:

1. Provision of open spaces, playgrounds, and amenities for the outside life of the family.
2. Construction of one- and two-family houses for families with small children.

Hitherto the attention of those concerned with housing was concentrated principally upon the dwelling itself and the life within and too little consideration given to the outside life of the family. A great deal of time is spent outside the walls of the house. It is just as important to provide space for outside life as space for sleeping, dining and living rooms within the building.

OUTSIDE SPACES

It is necessary to provide yards, courts, playgrounds, parks, wading pools, sailing pools, bathing beaches, and space for public baseball fields, tennis courts, and golf courses, where children can obtain opportunities for self-expression in some form of activity and where all the family can participate in group activities. This is largely a question of providing a good mental hygiene environment which will be of inestimable value in securing and maintaining good physical, mental and social health. In effect, it means the provision of parks and playgrounds for the pre-school and school child and for the grown-ups.

These play spaces should be permanent, year round, readily accessible, properly equipped and adequately supervised with trained year-round leaders. They are just as essential as the recognized public health services, including water supply, drainage, safe food and welfare facilities.

It is now taken for granted in every modern community that space for play and recreation must be provided for the outside life of the family. The old idea that play is unnecessary and a waste of time has long since given way to the present-day knowledge that it is vitally needed for the health and happiness of child and adult alike.

Plenty of play in the open air develops the child physically, mentally and socially. The value of play in the development of physical health has long been known. An appreciation of its importance in the promotion and maintenance of mental health is of comparatively recent date. Proper play develops the child mentally, brings out his personality, helps to form his character, controls and trains his emotions which are the great generative powers behind behaviour. It promotes social contact which makes it easy for the child to adapt himself to any environment and gives him confidence in going out into the wide world of work. In this strenuous age of machines, speed and tension, wholesome play strengthens the body and nervous system against the depressing influence of mental strain and stresses. Supervised play will develop creative habits in children and thus tend to prevent emotional upsets, behaviour problems and delinquency. It is of the greatest value in the integration of muscle, mind and emotion, gives great pleasure when indulged in, and to the child it is life itself. If wholesome recreation is not at hand, undesirable outlets for the play-urge will be sought and found and these may take the form of excessive day-dreaming, shyness, sensitiveness, suspicions, withdrawals from society. This failure in social adaptation may contribute to various kinds of serious personality disorders.

While the provision of community service is not usually considered an integral part of housing programs, yet it is so closely associated with the housing program and is so necessary that it deserves mention.

An essential requirement in the development of adequate mental health and social adjustment is the establishment, in any town planning or housing project, of facilities for participation in group activities. This implies the provision of community halls with kitchen service, recreational and educational centres, gymnasium, skating-rinks, space for handicraft activities and welfare stations.

That there is a serious shortage in play and leisure space in Canada and the United States is seen from statistics compiled on the subject. Rogers says: "Some twelve million urban children and probably more than fifteen million rural children in the United States still do not have opportunities to avail themselves of a playground program." In the metropolitan city of Montreal, the available play space probably does not come within 20 per cent. of the requirements.

The reason for the lack of play space in urban and rural districts is usually the ignorance and indifference of the public with regard to the need for such. It is encouraging to note that after an educational campaign showing the value of play in the physical, mental and moral upbringing of children, many American cities were quite prepared to tax themselves in order to provide the required facilities.

Cities, smaller towns, and villages would be well advised to set aside, a considerable time in advance, the space areas that will be required in the future. This is necessary in order to secure accessible recreational areas before the inevitable increase in land prices makes this difficult, if not impossible. Arrangements should be made that any such areas should remain as a permanent part of the neighbourhood setting.

CONSTRUCTION OF ONE-FAMILY HOUSES FOR FAMILIES WITH SMALL CHILDREN

It is practically true to say that medical opinion everywhere almost wholly favours the provision of one-family houses rather than multiple dwellings for the housing of the people.

Consequently, it is the responsibility of physicians, whenever the occasion presents, to direct the attention of the public to the desirability of living, where possible, in one-family dwellings.

Briefly, and without going into well-known details, some of the advantages are as follows:—

- (a) More sunlight.
- (b) More fresh air and greater opportunities for taking exercise.
- (c) Cooler in summer.
- (d) Less heart strain.
- (e) A lower incidence of communicable disease.
- (f) Provision for a fuller family life.

In emphasizing the superiority of single family houses, it is fully appreciated that good housing conditions are not at all incompatible with life in multiple dwellings. It is also realized that it may be economically impossible, in the big industrial cities, to construct low-rent single family houses for the low-income groups. Admittedly, it is impossible to lay down any hard and fast rule as to whether one-family houses or multiple houses should be built. Each local authority must deal with its own problems.

Although no definite studies have been made of housing conditions in the rural areas of Canada, nevertheless information which has been received from the Chief Provincial Health Officers of the provinces indicates that rural housing is comparable to that of the cities with the exception of the fact that there are no typical slum areas such as are found in urban districts.

To sum up, Eastern Canada is better provided with housing accommodation than Western Canada. Of the Western Provinces, British Columbia is probably better provided than any of the older provinces. The situation in regard to urban homes is less favourable than in rural areas, although housing in the latter is unsatisfactory. Crowding in low rental houses is extreme. The chief cause of crowding is insufficient income. The immediate problem to be faced is the need for houses for war workers and a long term program to compensate for obsolescence of existing houses and diminished construction of new houses. It is considered that Canada requires approximately 60,000 new dwelling units per annum, whereas the construction of new housing units has averaged only 15,000 dwellings per annum. Of this number, the National Housing Act has provided 4,000. It is estimated that we have lagged behind to the extent of 200,000 dwelling units during the last five years. It is indicated that the post-war task of providing adequate housing requires careful planning and that any such plan should cover the whole country. It should be the work of experts.

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3. "Housing and Public Health," by John Robertson, C.M.G., O.B.E., M.D.
4. Public Health Reports of the United States Public Health Service, November 2, 1934.
5. Report of the Lieutenant-Governor's Committee on Housing Conditions in Toronto, 1934.
6. Report of the Ontario Housing Committee, 1919.
7. "Progress in Housing and Health," by Dr. R. St. J. MacDonald.
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Canada, Social Security, Special
" Ottawa, 1943

SESSION 1943

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE
AND THE SECOND, THIRD AND FOURTH REPORTS.

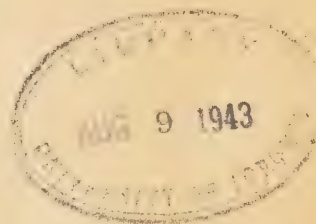
No. 28

THURSDAY, JULY 8, 1943

FRIDAY, JULY 16, 1943

TUESDAY, JULY 20, 1943

WEDNESDAY, JULY 21, 1943



OTTAWA

EDMOND CLOUTIER

PRINTER TO THE KING'S MOST EXCELLENT MAJESTY

1943

REPORTS TO THE HOUSE

OTTAWA, JULY 8th, 1943.

The Special Committee on Social Security begs leave to present the following
as a

SECOND REPORT

Your Committee recommends that it be granted leave to sit while the House is sitting.

All of which is respectfully submitted.

CYRUS MACMILLAN,
Chairman.

WEDNESDAY, July 14, 1943.

The Special Committee on Social Security begs leave to present the following as a

THIRD REPORT

Pursuant to Order of Reference dated March 8th, 1943, your Committee has studied the question of Physical Fitness and recommends for the consideration of the House the attached draft Bill intituled "An Act to establish a National Council on Physical Fitness".

All of which is respectfully submitted.

CYRUS MACMILLAN,
Chairman.

FRIDAY, July 23, 1943.

The Special Committee on Social Security begs leave to submit the following as a

FOURTH REPORT

It was obviously impossible to consider, this session, all the problems involved in a program of Social Security. Only certain urgent phases could therefore be discussed. Recognizing that the primary basis of Social Security is Health, the Committee considered first the Act to establish a national council for Physical Fitness, and the Health Insurance Bill prepared by the Advisory Committee on Health Insurance appointed by Order in Council, P.C. 836, of the 6th of February, 1942. All the organizations which desired to give evidence were permitted to do so, either in person or by submitting a brief for the record, and no applicant was refused a hearing. It was the opinion of the Committee that, because of the importance of the subjects under discussion, complete representations on the part of all concerned should be encouraged. The Committee held thirty-two meetings, examined one hundred and seventeen witnesses representing thirty-two organizations.

The Act for the establishment of a national council for Physical Fitness has already been approved by the Committee and has been reported to the House.

The Committee approves of the general principles of Health Insurance set forth in the Health Insurance Bill, respecting public health, health insurance, the prevention of disease, and other matters relative thereto.

The Committee recommends:—

1. That before the Bill is approved in detail or amended and finally reported, full information regarding its provisions be made available to all the provinces.
2. That to provide this information, officials of the various government departments concerned be instructed to visit the various provinces and to give full details of the proposed legislation to the provincial authorities.
3. That, if possible, before the next session of Parliament, a conference of representatives of the Governments of the various provinces and the Dominion be held to discuss certain complex problems involved, especially financial and constitutional questions.
4. That in the light of all the information meanwhile obtained, study of the Bill be continued by a committee of the House and by the Advisory Committee on Health Insurance.
5. That the Government review the existing regulations governing Old Age Pensions, Pensions for the Blind, and War Veterans' Allowance, and consider the advisability of adjusting the eligibility age to a lower level and of increasing the amount of pension.
6. That an investigation be made into conditions and bases of grants of these pensions in the various provinces, cost of subsistence, inequalities, responsibility for and distribution of obligation, and all the matters relating to the problems involved, in order to effect greater co-ordination, equality and adequate adjustments.
7. That a study of a program of Social Security be continued during the next session of Parliament, with the object of making a co-ordinated framework of the various topics and problems.
8. That this Committee, or the Committee subsequently appointed to consider Social Security, be provided with necessary research assistance.

A copy of the evidence and proceedings is appended hereto.

All of which is respectfully submitted.

CYRUS MACMILLAN.

Chairman.

THURSDAY, July 8, 1943.

The Special Committee on Social Security met this day at 10.40 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Cleaver, Coté, Donnelly, Fauteux, Fulford, Gershaw, Kinley, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), Macmillan, Maybank, Shaw and Wright.—15.

The Chairman informed the Committee he had received a letter from Mr. J. R. G. McVity, D.O., Treasurer of the Canadian Osteopathic Association, enclosing reply to a question by Mr. McCann, M.P., on page 608 of the evidence, respecting osteopaths appointed as life insurance examiners.

He also received a letter from Mr. A. W. Macfie, Secretary-Treasurer, Board of Regents, submitting replies to questions asked during their presentation of evidence on June 4 last.

On motion of Mr. MacInnis it was

Ordered:—That these documents be printed in the evidence.

On motion of Mr. Cleaver, the Second Report of the Committee, asking leave to sit while the House is sitting, was adopted.

The Committee adjourned at 10.50 a.m. to meet again at the call of the Chair.

FRIDAY, July 16, 1943.

The Special Committee on Social Security met this day at 11.30 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Coté, Gershaw, Howden, Johnson (*Bow River*), Kinley, MacInnis, Mackenzie (*Vancouver Centre*), McKinnon (*Kottenay East*), Macmillan, McGarry, Mayhew, Shaw and Warren.—14.

In attendance were:—Dr. D. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health; Mr. A. D. Watson, Chief Actuary, Department of Insurance; Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health; Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics; Mr. S. B. Smith, Chief, Business Statistics, Dominion Bureau of Statistics; Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics; Col. J. R. Munroe, Chief, Finance Statistics, Dominion Bureau of Statistics.

The Chairman read a memorandum addressed to him by Hon. Ian Mackenzie containing a resolution of approval of social security action taken by the Government. Said resolution was forwarded to the Prime Minister by the Quinte Conference of the United Church of Canada.

The Chairman also read a letter from Miss Elizabeth Wallace, Executive Secretary, Canadian Association of Social Workers, Toronto, Ont., stating that they would like to present a brief in the fall. It was agreed that their brief would be accepted.

A letter from Mr. J. C. G. Herwig, General Secretary, Canadian Legion, was read. An enclosed letter from Mr. D. J. Corrigan, Commissioner, Canadian Red Cross Society, to Lt.-Col. W. C. Nicholson, Vice-President, Canadian Legion, together with a report by Dr. Grant, dated June 15, 1943, was ordered to be printed in the evidence as supplementary to Col. Nicholson's submission on July 6 last.

The Chairman expressed the Committee's regrets at hearing of the sudden death of Lt.-Col. Nicholson.

Old Age Pensions, Pensions for the Blind and War Veterans' Allowances were considered. On motion of Mr. Mayhew it was agreed that the Chairman draft a recommendation respecting these subjects for consideration at the next meeting.

The Committee resumed consideration of the draft Health Bill.

Clause 3 was amended by inserting the word "general" before the word "Public" in line 8 thereof.

The First Schedule was amended as follows:—Under "Designation of Grant"—(4) "Youth (physical fitness)" was changed to "Crippled Children."

Under "Objects of Grant"—(4) after the words "Program for the" delete the words "physical development of youth" and substitute therefor the words "prevention and control of crippling conditions in children."

Under "Special Conditions governing Grant"—(4) substitute the word "plan" for the word "scheme" and delete the words thereafter.

Clause 3 and the First Schedule as amended were adopted.

As the Committee has insufficient time to consider the Draft Bill clause by clause it was decided that the Chairman should prepare general recommendations for consideration at the next meeting of the Committee.

The Committee adjourned at 1.00 o'clock, p.m. to meet again at the call of the Chair.

TUESDAY, July 20, 1943.

The Special Committee on Social Security met this day at 11.30 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Bruce, Casselman (*Mrs.*), Coté, Donnelly, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Lalonde, MacInnis, MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, Mayhew, Picard, Shaw, Veniot and Wood—20.

In attendance were:—Dr. J. J. Heagerty, Director of Public Health Services, Dep't. of Pensions and National Health; Mr. A. D. Watson, Chief Actuary, Department of Insurance; Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health; Mr. J. T. Marshall, Chief, Vital Statistics; Mr. S. B. Smith, Chief, Business Statistics; Col. J. R. Munroe, Chief, Finance Statistics.

The Chairman read a draft report he had prepared at the request of the Committee. This was considered and certain clause were to be redrafted.

The Committee adjourned at 1.00 o'clock p.m. to meet again Wednesday, July 21, at 4.30 p.m.

WEDNESDAY, July 21, 1943.

The Special Committee on Social Security met this day at 4.30 o'clock, p.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Bruce, Casselman (*Mrs.*), Donnelly, Fulford, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Leclerc, MacInnis, MacKinnon (*Kootenay East*), Macmillan, McGarry, Picard, Shaw, Warren and Wood—19.

In attendance were:—Mr. A. D. Watson, Chief Actuary, Department of Insurance; Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health; Mr. J. T. Marshall, Chief Vital Statistics; Mr. S. B. Smith, Chief, Business Statistics; Dr. J. J. Heagerty, Director of Public Health, Services, Department of Pensions and National Health.

The Committee resumed consideration of the draft report as amended and unanimously adopted it.

The Chairman thanked the members of the Committee for their co-operation.

The Committee adjourned at 6.00 o'clock, p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

THE CANADIAN RED CROSS SOCIETY

3416 McTavish Street

MONTREAL, July 6, 1943.

Lieut.-Colonel W. C. NICHOLSON, K.C., D.S.O., M.C.,
Vice-President, Canadian Legion B.E.S.L.,
507 Place d'Armes, Montreal, Que.

MY DEAR BILLY,—We are very much concerned with the condition of the War Veterans Allowance cases. Recently we have had a number of these to deal with and the situation is appalling to say the least.

The Government gives a War Veteran's Allowance case, single man, \$20.00 a month, plus \$5 cost of living bonus but does not allow him to earn more than \$5 making a total of \$30 a month. The result of this is that these men are living in doss houses and the cases that we have are mostly living in a privately run doss house with 40 men in a room where they pay \$3 a week and the conditions are most unsanitary. It is a disgrace that veterans who served in the last war should have to submit to such conditions.

To just give you one instance, there is a man living there who had very good service and was suffering from shock brought on from malnutrition but by careful treatment in our Clinic and supplying him with the necessary vitamins the doctor was able to bring him to a condition where he could earn a living. The man got a job at \$20 a month but when he filled out the card which had to be taken to the Department the employer was informed that the man could not earn more than \$5 a month. The man started to work for \$5 and naturally the employer benefitted to the extent of \$15 a month which, of course, is ridiculous. The man, however, could not subsist on the \$30 due to the fact that while he was working he needed heavier meals and as he could not come to our Convalescent Home for meals he had to get them in a restaurant. The result was that he had to give up his job.

Our contention is that the Government should treat a War Veterans Allowance case the same as they do a pension and let the man earn all he can. None of them would ever earn very much and the man would be of some use to the country.

I discussed this whole question with Mr. Walter Woods, the Associate Deputy Minister of the Department of Pensions and National Health on June 16 and he stated that the Department was entirely in favour of this arrangement but the Finance Minister would not agree to this as it would upset the Old Age Pension Rates.

I would draw to your attention the statement made by the Minister of Pensions in Toronto where he states that—"The men of the present war are to receive a post-discharge of \$44.20 a month, while engaged in vocational training". How can they justify the distinction between that rate for the men of the present war and the rate of \$30 allowed for men of the last war?

I am attaching herewith copy of a report from Dr. Grant who conducts our Clinic at 902 Inspector Street.

I notice that Alex Walker is suggesting that the War Veterans Allowance be increased but we feel it might be easier to have them remove the restriction on the earning power of these War Veterans Allowance cases.

Colonel Leggat would very much like to meet you to discuss this whole question to see if something cannot be done through the joint efforts of the Legion and the Red Cross.

Will you please give me a call after you have read this to see if we can arrange a meeting.

Yours sincerely,

(Signed) DAVE.

D. J. CORRIGALL,
Commissioner.

Copy

THE CANADIAN RED CROSS SOCIETY

QUEBEC PROVINCIAL DIVISION

Copy of Dr. Grant's Report dated June 15, 1943

"I feel that the soldiers of the last war who are getting the W.V.A. of \$25 a month are unable to live adequately on that amount plus the \$5 extra which they are allowed to earn. At present prices for food and rooms this is insufficient even for meals and a bed. Practically all of them suffer from malnutrition. For their clothing and the numerous odds and ends they are dependent on charity. Ninety per cent of the medicine given at the Red Cross Clinic is Vitamin Concentrates to supplement their inadequate diet. Many of them could and would earn a small amount to supplement their allowance but the W.V.A. law only permits a veteran to earn \$5 a month extra. This sum does not make up for the extra expenses he has while he is working as he requires to buy his meals at a restaurant. The result is that he *can't afford to work*, he is worse off than he was before. Even now a man who has been on W.V.A. or relief for some years is not in a physical condition to earn very much. *If he were permitted to earn as much as he can along with the \$25 a month he would approach a decent standard of living.* Canada would profit from his labour and the charities would be partially relieved of a heavy burden. The lot of the veteran would be a happier and healthier one. To illustrate this I will cite the case of Robert Bromley, who has been incapacitated because of poor nutrition and was put in an incurable home. Since attending C.R.C. Clinic, following discharge from the Home, with vitamins by mouth and injection, his condition improved so that he began to work, he could only earn about \$20 a month which is about all that could be expected of him after years of idleness and malnutrition. He found out that he would not be allowed to earn more than \$5 a month. As he required to buy his meals while working he was obliged to give up, stating, 'I cannot afford to work', it being impossible to pay for meals at restaurant prices."

As per request at the time of appearance of the Board of Regents, Province of Ontario, committee, June 4, for the number of Chiropractors, Drugless Therapists and Osteopaths registered at first registration and the number coming into the province since that date, I beg to submit the same to you as follows:—

Number of Chiropractors and Drugless Therapists First Registration, June 1, 1926.....	517
Number of Chiropractors and Drugless Therapists Registered by Examinations and Reciprocity from June 1, 1926, to June 1, 1943	166

Total Chiropractors and Drugless Therapists Registered to date.	683
Number of Chiropractors and Drugless Therapists removed from Register by Withdrawal, Removal, Cancellation and Death.	266
Number of Chiropractors and Drugless Therapists on Register as at June 1, 1943	417
Number of Osteopaths, First Registration June 1, 1926.....	94
Number of Osteopaths Registered by Examinations and Reciprocity from June 1, 1926, to June 1, 1943.....	70
Total Osteopaths Registered to date.....	164
Number of Osteopaths removed from Register by Withdrawal, Removal, Cancellation and Death.....	49
Number of Osteopaths on Register as at June 1, 1943.....	115

CANADIAN OSTEOPATHIC
ASSOCIATION
(INCORPORATED)

From the Office of Treasurer,
2904 Yonge Street,
Toronto, 12, Ontario.
July 2, 1943.

The Honourable CYRUS MACMILLAN, M.P.,
Chairman,
Special Committee on Social Security,
House of Commons,
Ottawa, Ontario.

DEAR SIR,—At the meeting of your Committee with representatives of the Canadian Osteopathic Association on Tuesday, June 15, the following question was asked by Mr. McCann, (Page 608, Lines 30 to 34, Minutes of Proceedings and Evidence No. 21.)

Now, then, you point out with reference to osteopathic physicians that in certain parts of the United States they are allowed to make reports which are accepted by accident and health insurance companies. the question I want to ask is this: is an examination of individuals by osteopathic physicians for life insurance accepted in any of those states?

In answer to Dr. McCann's question, as promised, I am now enclosing a partial list of Life Insurance Companies which have appointed osteopathic physicians as examiners.

Very sincerely yours,

J. R. G. McVITY, D.O.,
Treasurer.

LIFE INSURANCE COMPANIES WHICH HAVE APPOINTED OSTEOPATHIC PHYSICIANS AS EXAMINERS.

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|--------------------------------------|---------------------------------------|
| Aetna Life Insurance Company | Fidelity Life Association, |
| Aid Association for Lutherans, | Fulton, Ill. |
| Appleton, Wis. | First National Life Insurance Co., |
| Alliance Life Insurance Company, | St. Louis, Mo. |
| Peoria, Ill. | The Fontennelle Insurance Company, |
| American National Assurance Com- | Omaha, Nebr. |
| pany, St. Louis, Mo. | Franklin Life Insurance Company, |
| American Reserve Life Insurance Co., | Springfield, Ill. |
| Omaha, Nebr. | Grange Mutual Life Company, |
| American National Insurance Com- | Nampa, Idaho. |
| pany, Galveston, Texas. | Great American Insurance Co., |
| American Underwriters Corporation, | Hutchinson, Kans. |
| Olympia, Wash. | Great Northern Life Insurance Co., |
| Bankers National Life Insurance Co., | Chicago, Ill. (Eye Dept.) |
| Denver, Colo. | Guaranteed Securities Life Ins. Co., |
| Bankers Reserve Life Insurance Co., | Topeka, Kans. |
| Omaha, Nebr. | Homesteaders Life Association, |
| Bankers Union Life Insurance Co., | Des Moines, Iowa. |
| Denver, Colo. | Illinois Bankers Life Assurance Co., |
| Beneficial Life Insurance Co., | Monmouth, Ill. |
| Salt Lake City, Utah. | Independent Order of Foresters |
| Capitol Mutual Association, | Jewish National Workers Alliance |
| Jefferson City, Mo. | Kansas City Life Insurance Co., |
| Central Life Assurance Company, | Texas Office. |
| Fort Scott, Kas. | Kansas Life Insurance Company, |
| Capitol Mutual Association, | Topeka, Kans. |
| Jefferson City, Mo. | Kentucky Central Life & Accident Co., |
| Central Life Assurance Company, | Anchorage, Ky. |
| Fort Scott, Kans. | Knights of St. George, |
| Colorado Life Assurance Company, | Pittsburgh, Pa. |
| Denver, Colo. | Liberty Mutual Life Insurance Co., |
| Columbia Life Insurance Company, | Kansas City, Mo. |
| Omaha, Nebr. | Liberty National Life Insurance Co., |
| Commercial Standard Insurance Co., | Birmingham, Ala. |
| Fort Worth, Texas. | Lutheran Mutual Aid, |
| Conservative Life, | Waverly, Iowa. |
| Wheeling, W. Va. | Metropolitan Life Insurance Co., |
| Country Life Insurance Company, | Mid-Continent Life Insurance Co., |
| Chicago, Ill. | Oklahoma City, Okla. |
| Crown Life Insurance Company, | Midland Life Insurance Co., |
| Toronto, Ontario. | Kansas City, Mo. |
| Durham Life Insurance Company | Missouri Insurance Company, |
| Equity Life Insurance Company, | St. Louis, Mo. |
| Omaha, Nebr. | Monarch Life Insurance Company, |
| Farmers and Traders Life Insurance | Springfield, Mass. |
| Co., Syracuse, N.Y. | Mutual Life Insurance Co. of New |
| Federal Life and Casualty Company, | York |
| Detroit, Michigan. | |

Mutual Trust Life Insurance Company, Chicago, Ill.

National Guarantee Life Company, Hollywood, Calif.

National Old Line Life Insurance Co., Wichita, Kans.

New York Life Insurance Company.

Columbus Mutual Life Insurance Co.

Gulf Securities Life Insurance Co., Corpus Christi, Texas.

John Hancock Mutual Life Insurance Co., Boston, Mass.

Woodmen of the World, Denver, Colo.

Royal Neighbors of America.

Indianapolis Life Insurance Company.

Occidental Life Insurance Co.

Ohio National Life Insurance Co.

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